FINAL REPORT

Mental Health Table Forum

Which Doors Lead to Where?

How to Enhance Access to Mental Health Service:

Barriers, Facilitators and Opportunities for Canadians' Mental Health

Delta Ottawa Hotel (*Algonquin Room*)
361 Queen Street
Ottawa, ON K1R 7S9
October 5-6, 2010

Representatives of the Mental Health Table:
Canadian Association of Occupational Therapists
Canadian Association of Social Workers
Canadian Pharmacists Association
Canadian Association of Speech-Language Pathologists and Audiologists
Canadian Medical Association
Canadian Nurses Association
Canadian Physiotherapy Association
Canadian Psychiatric Association
Canadian Psychological Association *(co-Chair)*
Canadian Federation of Mental Health Nurses
Registered Psychiatric Nurses of Canada
The College of Family Physicians of Canada *(co-Chair)*

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[*] The views expressed during the Forum or in its materials do not necessarily represent the views of Health Canada.

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EXECUTIVE SUMMARY

This report documents the proceedings of a Forum on access to mental health services and supports in Canada convened by the Mental Health Table and funded by Health Canada in October of 2010.

Who is the Mental Health Table? The Mental Health Table (MHT) formed in 2009 in recognition by regulated health care providers that there is an ongoing need for a venue for them to share, network, and explore issues and perspectives relevant to advancing mental health promotion and front line[†] mental health care delivery in Canada. Regulated health care professionals are but one set of stakeholders in Canada's mental health and we remain committed to partnerships with consumers, families, communities, institutions and government in the advancement of mental health and mental health care. A description of MHT member associations can be found in Appendix F.

Why a Forum on access to mental health services and supports? Access to health services is a key health issue among Canadians and government. Much of this focus has been on access to health care services for physical problems. Providing timely access to high-quality health care by reducing wait times for assessment and treatment is one of the top priorities for health care policy-makers in Canada. Missing among these priorities is a focus on mental health services, particularly access to a range of biological, psychological and social assessments and interventions and the health care professionals who provide them. It is for this reason that the MHT developed and sought funding for a Forum expressly to look at barriers, facilitators and opportunities to the delivery of effective mental health care in Canada.

Overview of Forum activities. The Forum hosted 80 delegates inclusive of health care providers, government, consumers of mental health care, as well as organizations representing consumers and providers of care and other NGO's (e.g. Mental Health Commission of Canada, Canadian Institute of Health Information).

The Forum featured several plenary sessions that addressed client perspectives in care, reports of issues and initiatives in other countries in delivering care, and issues and status of evidence-based care. Following each plenary session, delegates assembled in working groups during three break-out sessions to answer a series of questions related to the theme of the plenary. There were student recorders at each working group table. The transcript of the main points of all working group discussions is included in Appendix G of the full report.

A narrative that synthesizes the working group discussions for each of the three breakout sessions can be found on page 8 of the report. It is this narrative, entitled: ***What the delegates***

[†] Front line denotes mental health care provided directly to a patient but which is not necessarily or limited to primary care.

had to say: Synthesis of working group discussions, along with the ***Delegates Recommendations*** on page 18, that constitute the core messages of this report.

Breakout session work. Breakout Session 1 followed the first plenary on client-centered care. It asked delegates to address the following questions.

1. How well are <u>providers</u> meeting the needs of consumers – what works well? What doesn't?
2. How well are <u>systems</u> supporting providers and consumers – what's working? What isn't?
3. What are the gaps and opportunities to better match demand to supply of mental health services and supports?
4. What might be some of the quick and not so quick changes we can make so that services and supports are more client-centered and more accessible?

Breakout Session 2 followed the second plenary in international perspectives on how health systems can facilitate access to services and supports. It asked delegates to address the following questions.

1. What is the match between what evidence says is best practice and what is accessible? Where are the gaps?
2. What are the barriers and opportunities to putting together a team that works?
3. What system change is needed to support the development and functioning of teams and services that deliver evidence-based care?
4. What other kinds of change are necessary in order for the right service from the right provider to reach the right person at the right time in the right place? (e.g. changes to workplace culture and context, changes to provider attitude, client expectation)

Breakout Session 3 asked delegates to address next steps to redressing gaps and barriers and advantaging opportunities to enhance access to mental health services and supports.

Key themes of recommendations made by delegates. Note that the recommendations summarized below and detailed in the report are not necessarily the recommendations of the Mental Health Table (MHT) nor the recommendations of the associations the MHT members represent. These are the recommendations made collectively by the delegates to the Forum upon which this document reports.

Delegates recommendations centered around **eight key themes**:

1. **funding** (review funding models to ensure access to necessary service and support)
2. **system structure** (develop and maintain systems that respond to consumer need and facilitate efficiency and effectiveness)
3. **organization, integration and collaboration** (support partnerships across stakeholders and sectors)

4. **consumer voice** at every decision-making table
5. **education and communication** (prevention, promotion, enhancing literacy, reducing stigma)
6. **training and practice of health care providers** (to work collaboratively, respond to needs of populations)
7. **standards and benchmarks** (establish best practice and evaluate outcomes)
8. **advocacy** for legislative change to enhance access and achieve parity for mental health treatments

INTRODUCTION

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Who is the Mental Health Table? The Mental Health Table (MHT) formed in 2009 in recognition by regulated health care providers that there is an ongoing need for a venue for them to share, network, and explore issues and perspectives relevant to advancing mental health promotion and front line[‡] mental health care delivery in Canada. Regulated health care professionals are but one set of stakeholders in Canada's mental health and we remain committed to partnerships with consumers, families, communities, institutions and government in the advancement of mental health and mental health care. A listing of the member organizations of the MHT can be found in Appendix A on page 70 of this report.

The MHT has several related purposes which include:

- Participate in the identification of problems common to health professional communities as they relate to the mental health of our patients. Use existing knowledge to recommend strategies to address common problems

- Through consensus, undertake concerted action on key strategies to transform mental health care delivery

- Exchange and share information among participating associations

- Contribute to inter-professional knowledge bases on mental health promotion and collaborative mental health care delivery

- Communicate the results and products of our deliberations and activities to members and other stakeholders and partners (e.g. consumers, families, communities, institutions and government)

- Liaise with other stakeholders and partners in mental health (e.g. consumers and families, communities, institutions, government).

- Respond collectively to and work collaboratively with the MHCC

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health care services for physical problems. Providing timely access to high-quality health care by reducing wait times for assessment and treatment is one of the top priorities for health care policy-makers in Canada. Missing among these priorities is a focus on mental health services, particularly access to a range of biological, psychological and social assessments and interventions and the health care professionals who provide them. It is for this reason that the MHT developed and sought funding for a Forum expressly to look at barriers, facilitators and opportunities to the delivery of effective mental health services and supports in Canada.

For more information about this report, the Mental Health Table, or the Forum, please contact the MHT's Co-Chairs:

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WHAT THE DELEGATES HAD TO SAY: SYNTHESIS OF WORKING GROUP DISCUSSIONS

Following each plenary session (See Forum Agenda in Appendix A), delegates assembled in working groups during three break-out sessions to answer a series of questions related to the theme of the plenary. There were student recorders at each working group table. The transcript of the main points of all working group discussions is included in Appendix G.

Although each plenary and the questions that launched the three break-out sessions differed considerably from each other, recorders' notes (see Working Group Discussions in Appendix G) reveal that the same themes recurred throughout all three break-outs and sets of working group questions. Delegates appeared to have consistent and specific things to say when it came to noting the barriers, facilitators and opportunities when it comes to mental health service no matter the questions asked. The narrative that follows summarizes the working group discussions for each of the three breakout sessions.

Breakout Session 1 followed the first plenary on client-centered care. It asked delegates to address the following questions.

5. How well are providers meeting the needs of consumers – what works well? What doesn't?
6. How well are systems supporting providers and consumers – what's working? What isn't?
7. What are the gaps and opportunities to better match demand to supply of mental health services and supports?
8. What might be some of the quick and not so quick changes we can make so that services and supports are more client-centered and more accessible?

What is working well and not so well when it comes to providers and systems meeting the mental health needs of consumers?

What is working well? Delegates consistently identified what wasn't working well more often than what was. People who understand how the systems (i.e. healthcare, justice, education) work or who have the help of a system navigator or manager do better. They also do better when systems are nimble and responsive to the diversity of client's needs. What works well is when there is a range of mental health providers and clients do better with those who are well trained when it comes to mental health. Systems that are organized around triage that provide good assessment as well as good urgent and ongoing care, work well as do services that have developed protocols. Delegates noted that people with resources (e.g. money, employment, live in urban centres) do better when it comes to coping with a mental health problem than

those who do not. Community mental health organizations do a good job as well, especially given their modest resources.

What is not working so well and what are the gaps and opportunities? Many areas were identified as working not so well which delegates tended to merge with their discussions about gaps and opportunities - these are summarized below.

Consumers lack input and participation in their care and within systems of care. Delegates repeatedly made mention of the need for managers or navigators to help clients figure out and access the services and systems they need. They noted that the system is not listening or recognizing the voice of individuals in decision-making. There is a lack of client choice in exercising care. Views were expressed which point to the complexities involved when trying to balance personal safety when a disorder might impair judgement, determine if judgment is impaired while respecting a client's role, and rights in making treatment decisions.

A **lack of coordination and collaboration with service systems** was also consistently mentioned. Some delegates talked about the lack of a system when it comes to the acute or chronic care of mental disorders. Unlike physical disease, there is no systems-level pathway to appropriate care. The fragmentation in services and treatments hinders rather than facilitates recovery. There was a view expressed that the system is failing both the consumer and provider of mental health care – consumers are limited in the services they can access and providers are limited in the time and type of service they can provide.

Some delegates identified the need for one door through which a client could access all needed services and supports whereas others identified the need for multiple access points. It was also pointed out that sometimes the doors which are most accessible may not be the best ones from a client care, efficiency or effectiveness point of view (e.g. emergency departments). Family physicians were identified as the easiest access point within the current system.

Delegates noted that once you do get in a door, there is a lack of coordination among services and treatments. The system is referral-oriented, has too many providers to work in isolation, and is stretched beyond its limit. A clear need to enhance the continuum of care through communication and coordination among community services, treatments, supports, and inpatient mental health services was identified.

Delegates noted that communication and coordination could be enhanced with the use of electronic health records. This would help make assessments more reliable (because they are based on common information) as well as enhance the experience of the consumer who wouldn't have to repeat his or her information. Concern was expressed, however, about the need to ensure the security of electronic records and the privacy of the information in them.

Inter-sectorial communication and coordination also need to be enhanced. People live and seek services across sectors – each system has its own forms, processes and turf which need to be rationalized and coordinated for more efficient and effective care.

Finally, with a lack of coordination and collaboration comes a lack of stewardship. No one is in charge and services, systems and providers are not sufficiently accountable.

A need for data was identified. We need to know what clients are experiencing, what service or supports they are seeking, what kinds of care health care providers are providing what to whom, as well as the impact of mental health on physical disease and other functions (e.g. work, school, family life). Data is critical to developing needed benchmarks for wait times in mental health and to knowing what kinds of services to resource where and for whom.

A lack of investment, both political and economic was underscored by delegates. The lack of system organization was seen to be due to a lack of leadership and incentive. Deciding what mix and quantity of health care providers is a challenge and the health professions often compete against, rather than collaborate with, each other. Cuts in one area are made at the expense of another often by happenstance.

Another theme that emerged was a **lack of resource when it comes to services and treatments for persons with mental disorders.** A lack of publicly funded health human resource was consistently noted by delegates but some delegates queried whether having more health care providers would produce better outcomes for consumers of care. As noted by one delegate, however, you can't measure the effectiveness of something that isn't there.

Other gaps included a lack of follow-up at the termination of care or service, a dearth of children's mental health services, a need for more outreach services to engage consumers in their communities, and more resource in rural areas. As concerns the lack of services for children, it was noted that diagnostic services needed to be enhanced so that appropriate services could be accessed and that there was a need to better transition from child care (which is family based) to adult care (which is individually based).

Delegates also noted that what might appear to be a lack of care from individual health care providers might actually be more systemic and related to the policies or procedures of a service or program. Finally, delegates noted that there needs to be political will to fund more resource – be it services, treatments or programs – for mental health.

Delegates noted that there are a number of effective treatments and services when it comes to mental health and these are not limited to medication. Some expressed the view, however, that medications are often offered first when other options might be indicated but not available. Clients want more time with their providers to understand the complexity of their mental health issues and the options available to them.

Delegates identified that **health care providers need training and support to best respond to the mental health needs of persons seeking their care** and that the current system is not configured to provide this training or support. Delegates noted that health care providers need to better respect their clients and each other. Some client delegates noted that they do feel

stigmatized and insufficiently respected by health care providers. Whereas front line providers of treatment and service might have ideas and wisdom about how care should be organized and delivered, they rarely have the authority to implement them. We need to ensure that health care providers acquire the skills and knowledge necessary to respond to the mental health care needs consumers bring to them.

Just as delegates noted a need for better training among health providers, they identified a **need for public education when it comes to mental health** as well. Mental health literacy among the population needs to be improved and there needs to be more focus and support for prevention, early intervention, and family communication. We need to support resiliency within our communities. Further, we need to ensure that people have information about where they can turn for service and support for mental health problems.

Providers need to better understand what different kinds of health care providers can do and offer to enhance client care. Delegates expressed the view that no single provider can meet all needs of all consumers of care – needs which vary from individual to individual and change within an individual across time. The **absence of coordination and collaboration among different kinds of service and treatment providers** was identified as a barrier to effective outcomes. Delegates identified a need for a partnership among clients, families, providers and sectors rather than a client-centred approach per se.

A number of **inequities were noted when it comes to meeting the needs of persons** with mental health problems. Persons with mental health problems who have limited means get limited help. Delegates noted that mental health issues are complex and, as is the case for physical illnesses, problems and disorders are many and varied. In addition, psychological factors or mental health conditions impact physical health problems as well. There was a view expressed that more "severe" mental illnesses, being more visible, are more apt to get care. Delegates also expressed the view that there is a lack of parity between mental and physical disorders when it comes to support, service and treatment. Delegates noted that some diagnostic labels (e.g. personality disorders) can limit rather than enhance access to treatment.

Inaccessibility to treatment and services was consistently identified by delegates – wait lists for publicly funded services are long and only those with means (higher incomes, extended health insurance) have access to the considerable mental health services that are not publicly funded. Persons with limited means get limited help. Although some delegates expressed the view that systems provided better support to those who had more personal resource, there was also the view expressed that there was tremendous variability and inequity in how people were supported in maintaining their personal resources like employment.

The ingredients to recovery do not only depend on the health care provider communities. **Communities and community services are critical to helping people deal with mental disorders**. Communities provide effective services and supports and social networks. With training, community programs and peer support workers can play necessary roles in people's

recoveries. These too need to be sufficiently funded and integrated into the systems that support mental health.

Delegates noted a **need for government at all levels to take leadership** in the delivery of services, supports and treatments in mental health. They noted a need for political will as well as legislation to support systems to better meet the mental health needs of their communities.

There is a **collective responsibility to advocate for mental health services and supports**. People need to speak up and make mental health care a priority item for politicians and get mental health included in public health plans. We need to address the factors that impede advocacy – the stigma associated with mental disorders, and the challenges a person with a mental disorder faces in advocating for him or herself.

What are some of the quick and not so quick changes we can make so that services and supports are more client-centered and more accessible?

Systemic level. Delegates identified some clear and consistent system changes. Delegates recommended that **funding and records should be attached to the patient** rather than residing with a facility or service provider, evidencing that this affords shorter wait times for service. Also consistent with a user driven approach, delegates suggested that primary care medical clinics should be funded with authority and responsibility to resource themselves in response to the needs of their communities. In support of electronic health records attached to patients, care must be taken to balance communication with privacy.

Delegates suggested that we need to adopt a **primary care and chronic disease management approach** in mental health rather than an episodic or acute care model of treatment and service delivery. There was support for inter-professional rapid response teams better designed to meet episodic or urgent issues related to mental health than traditional hospital emergency departments.

Delegates were clear in the need to **enhance collaboration and coordination** in the delivery of care. This requires investment in teaching health care providers to work collaboratively and creating systems that support collaborative practice.

Also favoured was a **one door/any door model** in which all of a client's needs (e.g. housing, treatment, etc.) could be addressed. Delegates suggested the use of **system navigators** to help consumers access the services and supports they need. Also recommended was establishing **standards for wait times** for mental health services and supports, and **evaluating services and supports via client satisfaction**.

Level of the health care provider. Delegates identified the need to **train sufficient numbers of health care providers who were equipped to meet the mental health needs of the populations with whom they work**. Appropriately trained providers at the front door make a

tremendous difference to a patient's trajectory through the system. A specific need was identified to **train health care providers to treat concurrent disorders concurrently.**

Delegates also noted that **primary care practice needs to routinely address mental health functioning** – to identify and respond to any problem that might need attention but also to normalize the idea that mental health is part of health. Delegates pointed out that the acute care model of providing general health care might not give people enough time to disclose sensitive or complex issues related to mental health.

Finally, when it comes to charting and recording, delegates identified a need to **standardize the assessment of mental health problems and conditions** – again something that might best be accomplished collaboratively by health care providers working in the area of mental health.

Education and communication. Delegates identified the need for **enhancing communication and education about mental health disorders**. We need to let people know how to recognize the signs and symptoms of mental disorders, where they can go for services and supports, and help them understand the personal and financial consequences when people don't seek help. There was a clear need identified to **increase the mental health literacy of all stakeholders – policy and decision makers, health care providers, and the general population**; this was seen as critical to redressing the stigma attached to mental disorders that stands in the way of people getting the help and support they need. Another key need identified was for **knowledge transfer when it comes to best practices in mental health** – delegates noted that **we know a lot about effective treatments, services and supports but we need to do a better job at implementing them**.

Create the business case for investing in evaluation, research and service in mental health. Delegates identified the need for a business case that demonstrates the costs of enhancing access to mental health services as compared to the costs of not doing so. Suggestions were made to demonstrate how the costs of treating mental health issues appropriately can be cost recovered through later productivity in the next ten years.

Breakout Session 2 followed the second plenary in international perspectives on how health systems can facilitate access to services and supports. It asked delegates to address the following questions.

5. What is the match between what evidence says is best practice and what is accessible? Where are the gaps?
6. What are the barriers and opportunities to putting together a team that works?
7. What system change is needed to support the development and functioning of teams and services that deliver evidence-based care?
8. What other kinds of change are necessary in order for the right service from the right provider to reach the right person at the right time in the right place? (e.g. changes to workplace culture and context, changes to provider attitude, client expectation)

What are the gaps, barriers and opportunities in accessing evidence-based care?

Delegates consistently pointed out that **changes in culture and political will** are **necessary to changing how services and treatment are delivered.** These changes were seen as critical to supporting a move to care which is collaborative and inter-professional and which provides for a continuity of care across settings (e.g. practitioner's office, hospital, community) and sectors (e.g. health, education). These changes are also necessary to ensure continuity in decision making across departments of health and government services which fund care. Delegates pointed out that many provincial governments have already demonstrated some policy and political will by funding primary health care teams. They also articulated that political will and investment is critical to incent change among services systems and providers.

The need for **organization and integration of the full range of services** was also identified as critical to delivering services and treatments that work. **Silos, across sectors, across jurisdictions, and across service providers need to be broken down**. **Teams need to be defined and constituted to meet the needs of the people they serve and include consumers and their families in making treatment plans and assessing treatment efficacy**.

The delivery of evidence-based services and supports also depend on the changes to the training, attitudes and practice of health care providers. Delegates discussed how scopes and mandates of practice can be at times narrow (e.g. treat one or only one aspect of a complex problem) but also overlapping such that fields of activity may be fiercely protected but poorly understood. Health care providers need to better understand each other's skills sets and scopes of practice, and value these for the benefit of patient care. Delegates underscored that health care providers need to respond to the needs of the populations they serve, and their expertise and training needs to equip them to do so. Further, their attitudes and approach to care needs to be engaging of, rather than prescriptive to, consumers of care.

Training of health care professionals needs to

- cover how to **practice collaboratively** with other health care providers as well as with consumers and other services and providers of care (e.g. peer support workers, community agencies, families)
- equip providers to **meet the specific health care needs of populations**
- include the **management of services and systems**
- include the **settings in which people live and present mental health problems** (e.g. practitioners' offices, schools, criminal justice settings)
- support mentoring by front line providers
- be competency-based
- impart standards of care developed for mental health

The delivery of evidence-based services and support also depends on **funding.** Lack of funding can limit access to medications and psychotherapies, as well as to specialized mental health providers (e.g. psychologists), that effectively treat mental disorders. Funding for community and peer services and supports that effectively support recovery is also critical. Delegates expressed the view that **funding and service decisions should be based on evidence of efficacy or what we know works.** We need to be accountable to service delivery and demonstrate cost and clinical effectiveness. Unlike current funding models, we need funding models that support collaborative rather than individual or parallel practice.

There appeared to be some **consensus that we do know a considerable amount about what works when it comes to services and supports for mental health**. There is a **gap, however, in translating this knowledge into guidelines and implementing these in practice.** As mentioned earlier, what works is not always what is funded when it comes to treatments, services and supports. Delegates also pointed to a disconnection between what we know works and what is offered. This disconnection may be related to funding but can also be related to gaps in knowledge and skill among those who deliver service and support. Delegates also pointed out that system pressures (e.g. large patient loads, long waitlists) challenge the implementation of best practices. Access to best-practice based services when it does exist can be limited by the exclusion criteria of the service (e.g. a service provided to only specifically defined groups of patients). Finally, delegates talked about the importance of practice-based evidence – researchers need to investigate the efficacy of interventions for real-world problems and the way in which they are presented (e.g. comorbid or concurrent disorders) as well as be guided by the realities and constraints attached to the delivery of care.

Education and communication. Delegates pointed out that access to evidence-based services and supports can be limited by the fact that consumers may not know what is best practice or where to get it. Delegates underscored a collective responsibility for knowledge translation in this regard. They pointed out the important roles that the media can play and the importance of funding to ensure that consumers have access to the information that will help them make informed choices about treatment and service.

Engaging key stakeholder groups outside of consumers, legislators and health care providers. Delegates also pointed out the need for education and communication about best practice in mental health to the personnel in other sectors who may not deliver mental health care but work with people with mental health issues (e.g. teachers, employers). Their ability to recognize signs and symptoms and point people in the right direction to access care can produce better outcomes that derive from early intervention. Education and communication is critical to changing the culture of settings such as school and workplaces, which in turn is critical to mental health promotion, prevention and early intervention when necessary. It is also critical to ensuring that the mental health services that other sectors provide access to (e.g. employee assistance programs, extended health care benefits) fund the kinds and amounts of services and treatments that people need and that are effective.

Breakout Session 3 asked delegates to address next steps to redressing gaps and barriers and advantaging opportunities to enhance access to mental health services and supports. As can be seen from Appendix A, discussions about next steps tended to merge with the recommendations identified by each working group at the end of each breakout session. The next steps summarized below focus on those that are actionable rather than general. Those that were more general are included in Recommendations.

Next steps: Increasing awareness, understanding and implementation.

Change is going to depend upon **advocacy and political will**. We need to engage stakeholders in advocating for system, cultural and legislative change. Delegates thought that the Mental Health Table could be an important advocacy group for change.

We need to create a **culture of inclusion**, supportive of the full and optimal range of peoples' physical, psychological, and social functioning.

Systems need to keep pace with what kind of care is needed for whom, from whom and where it is needed. Traditional systems of health care delivery do not necessarily adapt themselves to evolving models of best practice.

Delegates agreed on the necessity of **engagement – communities, consumers, health providers and legislators** – to enhance the delivery of needed and effective services and supports in mental health. They talked about the need for a conceptual shift so that the role of mental health in health was considered, recognized and accounted for.

In discussing needed and effective services, stakeholders tend to get immersed in discussion rather than focused on action and implementation. **More needs to be done about what is known and discussed.** Decisions need to focus on whether we want an efficient system and/or an effective and responsive one.

We need to attend to Canada's **health human resource** when it comes to mental health – we need to appraise whom we need more of in order to provide what kinds of services and to meet what kinds of needs.

Make **electronic health records** a reality.

Delegates indicated that we need to continue to **dialogue among all stakeholders in mental health such as this Forum**. Dialogues provide important opportunities for knowledge transfer and networking about what is needed and what works. Delegates further thought that the range of stakeholders attending the Forum should be both broadened and deepened to include representatives from education, criminal justice and industry as well as more representation from federal and provincial/territorial government.

Health care providers need to work with their own communities to advocate for training that equips providers to meet the needs of communities and practice collaboratively. The understanding and will among health care providers to practice more collaboratively has grown considerably and we need to continue to invest in the culture and system change that will support it.

We need to work together to ensure that **mental health issues, services and supports are addressed in 2014 health care renewal.**

We need **leadership**. Forums such as this allow for rich discussion and multiple recommendations but will fall short of effecting change if responsibility is too diffuse and authority non-existent.

Next steps: Some specific recommendations and cautions generated by delegates to the Mental Health Table as they contemplate next steps

The Mental Health Table (MHT):

1. needs to work together to ensure that we don't produce a well-intended report that has no traction

2. can develop a plan for moving forward on the Forum's work and its recommendations

3. can participate in public forums, community planning and town hall meetings where issues related to mental health and mental health care are decided and discussed

4. can work with media to help communicate about what is known and needed about effective mental health care

5. can create a mental health services and supports report card

6. should develop an executive summary that can easily be used to communicate the Forum's proceedings

7. should take the Forum's proceedings back to our respective communities in support of the changes in systems and practice that are indicated for Canada's mental health

DELEGATES RECOMMENDATIONS

Note that the recommendations that follow are not necessarily the recommendations of the Mental Health Table (MHT) nor the recommendations of the associations the MHT members represent. These are the recommendations made collectively by the delegates to the Forum upon which this document reports.

Funding

1. Review and revisit funding models of mental health services and support.

2. Funding and support from government and other sponsors is needed for community programming and services and to increase mental health literacy among Canadians.

3. Provide funding for needed service and service providers. When it comes to mental health care, the services of several needed and necessary providers are insufficiently funded and their services hence inaccessible to many Canadians (e.g. psychologists, occupational therapists, social workers).

4. Enhance access to services, supports and their systems of delivery, and resource these with the necessary health care providers. Ensure the right service gets to the right person in the right place at the right time from the right provider(s).

System structure

5. Support primary care reform that includes mental health as a focus of care and in which health services and providers are funded in a way that responds to the needs of the communities of individuals they serve.

6. Employ systems' navigators to help people access the services and supports they need.

7. Support flexibility within system and within provider' practice.

8. Organize services and supports based on what the consumer needs not what the provider or system needs in the context of what is possible.

9. Break down the silos in the system and resource a structure that provides seamless and more responsive care for people with mental health problems.

10. Attach funding and health information electronically to a person with which they can "purchase" services and have their health care record always available and up to date.

11. Employ technology to extend the reach of care (e.g. telemental health).

Organization, integration and collaboration

12. Enhance partnerships, communication, coordination and collaboration among all stakeholders in mental health.

13. Create an integrated and fluid health system that comprises services in the public and private sectors and that engages consumers, caregivers and communities. There needs to be an effective continuum of care for mental health.

14. Leverage what services and support have been shown to work in some communities for use in others.

Consumer voice

15. Include consumers at every decision-making table.

Education and communication

16. Enhance what is offered to populations in terms of mental health promotion, prevention and early identification. We need to educate and communicate and increase the mental health literacy of all stakeholders inclusive of schools, workplaces and communities. We need to ensure that people increase what they know about mental disorders, recognize when help might be needed, and know where they can turn for help.

Training and practice of health care providers

17. Train health providers so that

    - collaboration is taught, practiced and supported
    - patients are treated as fairly and respectfully for their mental health problems as they are for their physical health problems
    - they have the knowledge and expertise to meet the needs of the populations they serve
    - they integrate mental health into their assessment and treatment of health problems
    - primary care and front line providers are supported by specialized mental health care providers

Standards and benchmarks

18. Develop standards for wait times for mental health services and supports.

19. Support training in mental health for all formal and informal healthcare providers.

20. Support best practices at the level of systems, services and treatment across providers and within and across jurisdictions. Establish national standards of mental health care.

21. Be accountable to services and supports

    - evaluate outcomes from the perspectives of the individual and other relevant stakeholders
    - empower teams to monitor and disseminate best practice and attend to the team's wellbeing

22. Close the gap between what we know works and what is accessible when it comes to mental health services and supports.

Advocate for change to enhance access

23. Advocate for the legislative changes necessary federally and provincially/territorially so that the right person gets the right treatment at the right time from the right providers in the right place. Create a system out of what is now a non-system.

24. Create parity between mental and physical health funding and service. A person who presents to health care with a mental disorder should be treated equivalently to one who presents with a physical disorder.

FORUM EVALUATION

Which Doors Lead to Where?
How to Enhance Access to Mental Health Service:
Barriers, Facilitators and Opportunities for Canadians' Mental Health

We are interested in hearing your feedback on the forum! You may provide us with your feedback by completing this form in hard-copy and leaving it with the forum organizers at the end of the forum. Alternatively, you may provide your feedback on-line via a survey link that will be sent to each of you following the forum. Thank you!

Total Number of Respondents	50	
Affiliation *(Check all that apply)*	8	Student
	12	Academia
	19	Non-Government
	3	Government
	25	Health
	10	Research
	9	Consumer
	1	Other (Please specify)

1 (Unsatisfactory) 2 (Poor) 3 (Adequate) 4 (Very Good) 5 (Excellent) N/A

1	**Forum Venue**	***Mean***
A	Meeting location and space	4.32
B	Guest rooms and hotel services	3.95
C	Food and beverages provided at the Forum	4.35
2	**Forum Registration**	***Mean***
A	Forum materials provided in advance and on-site	4.30
B	Registration process	4.71
C	Communication and support provided by the Forum's organizers	4.61
3	**Facilitator**	***Mean***
A	Communicated well	4.67
B	Effectively managed and engaged speakers and participants	4.65
C	Provided the support you would expect from a facilitator so that the Forum could meet its objectives	4.63
4	**Forum Agenda**	***Mean***
A	Met its objectives	4.27
B	Mix of breadth and depth in sessions	4.30
C	Number of sessions and speakers	4.27
D	*Number* of break out sessions	4.06
E	*Format* of the break out sessions	4.06
F	Audiovisual and other technical support	3.81
5	**Plenary Session #1: Client-Centered Care Panel**	***Mean***
A	*Presentations were* relevant to the Forum's objectives	4.76
B	Speakers were knowledgeable	4.74
C	Speakers were interesting	4.72
D	I learned at least one new thing from the speakers	4.73
6	**Plenary Session #2: International Perspectives on How Health Systems can Facilitate Access to Services and Supports - Panel**	***Mean***
A	*Presentations were* relevant to the Forum's objectives	4.60
B	Speakers were knowledgeable	4.67
C	Speakers were interesting	4.47
D	I learned at least one new thing from the speakers	4.64

1 (Unsatisfactory) 2 (Poor) 3 (Adequate) 4 (Very Good) 5 (Excellent) N/A

	Question	
7	**Review of MHCC Strategy Consultation**	***Mean***
A	*Presentation* was relevant to the Forum's objectives	4.33
B	Speaker was knowledgeable	4.55
C	Speaker was interesting	4.15
D	I learned at least one new thing from the speaker	4.15
8	**Plenary Session #3: Evidence Based Mental Health Care Panel**	***Mean***
A	*Presentations* were relevant to the Forum's objectives	4.56
B	Speakers were knowledgeable	4.65
C	Speakers were interesting	4.49
D	I learned at least one new thing from the speakers	4.53
9	**Plenary Session #4: Service Delivery Mix Panel**	***Mean***
A	*Presentations* were relevant to the Forum's objectives	4.61
B	Speakers were knowledgeable	4.69
C	Speakers were interesting	4.63
D	I learned at least one new thing from the speakers	4.64
10	**Forum Learnings**	***Mean***
A	The format of this session was an effective way of evaluating what we learned during the Forum	4.33

Additional Comments

- Very well organized; organizers and facilitators were very welcoming and helpful
- Problems with temperature
- Problems with sound system (skype, microphones)

- Excellent decision to have the consumer panel first; very powerful presentations
- Mix of presentations was excellent and stimulated discussion, reflection on the continuum of mental health services, and problem-solving ways to improve the system
- Would have liked to have seen presentations and articles that covered a broader approach to collaborative practice – seemed psychiatry and psychology heavy
- Some of the panellists were not sufficiently engaging

- Some repetition among reporters from break-out sessions; went on too long at times
- Some of slides were too hard to read, especially from the back of the room

- Limited time for networking as many presentations went over time allotted (this cut into scheduled breaks and break-out sessions)
- Could have benefited from a few more breaks so as to minimize information overload

- Many new partnerships emerged
- Liked the variety and representation of the table assignments
- Compelling atmosphere
- Receptivity to new perspectives was apparent
- Very good inter-professional respect
- Wonderful learning opportunity
- Excellent content

- Would have liked to have seen a broader range of providers, community partners (e.g. Boys and Girls clubs, Salvation Army, Crisis Lines) and policy-makers in the audience
- Sectors such as education, health, justice weren't represented in audience
- Would have liked more recognition of training and role that nurses play in mental health service provision
- Mental health services/support can't just be given during business hours
- MHCC needs to actively leverage primary care system change
- Ensure that concrete next steps are put into place so that work and energy of the forum are not lost

POST FORUM SURVEY

Which Doors Lead to Where?
How to Enhance Access to Mental Health Service:
Barriers, Facilitators and Opportunities for Canadians' Mental Health

Survey Period: March 11- 25, 2011

OVERVIEW

Delegates to the Forum were surveyed on a number of topics 5 months after the Forum took place. The raw data from the survey are presented below and a brief overview follows. **Thirty-nine respondents or 49% of all Forum delegates responded to the post Forum survey.** Respondents represented a number of constituent groups (see responses to the first survey question about the capacity in which the delegate attended the Forum) but the largest constituent group was health professionals.

Over half the respondents replied that the Forum helped them to understand the issues faced by health providers in delivering service to people with mental health problems. **Just under a third of respondents said that they have been able to act on recommendations** arrived at by delegates during the Forum's working group discussions and **just under half the delegates said that their attendance at the Forum influenced their subsequent work**. In describing the Forum's impact, comments suggested that the **presentations and discussions helped increase awareness among delegates and resulted in knowledge transfer**. **Over a third of delegates said that they have networked with contacts made at the Forum and over one half of delegates said that they shared the information** they gained at the Forum with other partners and colleagues.

Respondents closing comments noted that the Forum was well run and organized and served as an excellent model for information sharing and that the presentations (particularly consumer presentations) were very compelling. **Respondents recommended that we continue to hold similar events in the future, and in particular with policy-makers, and that we disseminate this report among stakeholders.**

SURVEY DATA: N = 39 respondents

In what capacity did you attend the forum?

Student	2	5.13%
Researcher	3	7.69%
Health Professional	17	43.59%
Federal Government Representative	6	15.38%
Provincial Government Representative	1	2.56%
Municipal Government Representative	0	0.00%
NGO or Not-For-Profit	7	17.95%
Consumer	5	12.82%
Academia	5	12.82%
Mental Health Table Member/Representative	9	23.08%
Other (please specify)	4	10.26%

What were your key learnings from the forum?

- My key learning is the fact that the government does not put in funding for mental health compared to other programs. Mental Health is so important in today's society and Illness is on the rise. The government has people's hands tied on which funding they give to certain programs and that is very frustrating considering there is 1 in 5 people diagnosed in Canada with a mental illness- its high in the number. There is very much still stigma surrounding mental health, unfortunately.
- barriers to access to adult mental health services - main consumer-identified barriers to mental health services - strategies to streamline care - changes in mental health services in other jurisdictions
- Better understanding of some of the international work in this area. Better knowledge of some of the key players in Canada doing work across the age span
- 1, How difficult it is to access services, even if you are a health care professional. 2. Barriers are systemic and as such make access for lower income Canadians very difficult to impossible to overcome. 3. Barriers are systemic based on a bio-medical centric health care system that is not prepared or organized to look after most Canadians with mental or behavioural health problems and disorders. 4. Discrimination leads to serious differential funding between mental and physical health.
- I was on the consumer panel and unfortunately did not have time to participate in the forum, other than giving my presentation.
- don't remember
- Good cross communication amongst various stakeholders to realize the barriers and the facilitators to mental health care system access.
- Creative approaches to increasing access to services.

- Increasing opportunity to move mental health agenda forward by using some mainstream medical paradigms, such as "chronic disease management". Also, need to make it part and parcel of a reformed primary care system.
- Valuable role of programmatic integration of MH into primary care
- Key learnings included information regarding the Anti-Stigma campaign, and hearing how it is still difficult to access services (the mine field of access from primary care or long-term care).
- Significant barriers exist to accessing mental health services - role of health professionals other than psychiatrists, psychologists and nurses virtually unknown
- Ongoing reinforcement to incorporate mental health users and supportive community in planning and evaluating programs. Other mental health professionals do not know the scope of practice of others in the field and this one to one explaining is required
- many different professionals have the same problems. The medical model where the physician controls most of the services is still lively and well.... but needs to change to a more collaborative approach.
- psychologists need to be recognized as bigger player by FPT government and covered under health plans value of inter-disciplinarity
- While understanding barriers in theory, I found that the forum increased my understanding of: - types and extent of barriers experienced by consumers. The consumer presentations resonated provided context. - types and extent of barriers experienced by professionals and service providers
- it will take a collaborative effort to affect change. This means that all parties represented at the table must agree to work together for the greater good of the patient. Professional protectionism is not an option.
- There needs to be engagement of all medical professions and stronger communication between the different areas if we are to see any improvements.
- *The importance of involving consumers as peers in initiatives aimed at increasing public, student and faculty awareness of the issues related to living well with mental illness. *While not a new insight, the value of enriching one's network was clearly illustrated in the conversations held at the tables and during breaks
- Learn about initiatives in Canada.
- Needs and resulting access issues are complex and current solutions are simplistic. Change Requires Three Elements
- Gaps and system issues are the main cause of wait times in receiving mental health services. Lack of services in areas like corrections and jurisdictional issues are also causing undue hardship for mental health consumers.
- accentuated knowledge regarding problems with access to mental health care - lack of knowledge of role of other health professionals in mental health care other than psychiatrists, nurses and psychologists
- Hearing multiple perspectives on the effect and effectiveness (or lack thereof) of services.
- confirmed that mental health is still stigmatized as health professional, I do not work enough with support groups

What actions have you taken following the forum to address your learnings about <u>barriers</u> to enhancing access to the biological, psychological and social interventions for Canadians with mental health problems and disorders?

- I have researched a lot of things in the last 6 months. One thing I found that there is not a set form for Psychiatric Advanced Directives in Canada- its just all encompassed within the Advanced Directives form. The Advance directives primarily focused on physical health and does not talk about when someone is in need of involuntary services. So I have had a lot of research on seeing what the states does in this regard and perhaps setting up a generic form to have for other people that are in need of making their Psychiatric Advance directives. Also, I am in the process of writing a letter to who ever is in charge of the BUILD program that has ended the funding- so many people rely on this program and they are not able to continue with the services due to funding. Funding always seems to be the issue.
- N/A
- Our Centre has participated in the creation of a policy-ready paper on access and wait times in child and youth mental health. This is serving as a background document for the current CIHR IHDCYH RFA in access and wait times in child and youth mental health. Through the National Infant Child and Youth Mental Health Consortium we have 1) conducted a webinar to further communicate the research opportunity in this area and 2) struck a working group to coordinate action in this area. Access and wait times will be a secondary focus of our next national symposium in child and youth mental health.
- 1. Discussed barriers with other provider and patient groups. 2. Developing plans to present to governments regarding improved access to mental and behavioural health services. 3. Examination of ways to improve access through primary care, school systems, criminal justice systems, child welfare systems and the work place.
- I am continuing my schooling to be of use to the mental health community in the future.
- think I told colleagues about it
- I will address the topic in my MBA Thesis tentatively titled: "Accounting for Mental Illness and Mental Health in Canada: The Private, Public, and Non-profit Sectors".
- Nil
- Ongoing work in shared mental health care; interest in more explicit role of primary care in addiction medicine. Development of various tools and strategies for both. Advocacy for aligned payment schema to support this work.
- Increasing options is necessary for screening and treatment using MD team based approach.
- In the Winter 2011 issue of CONTACT (the Official Newsmagazine of Canadian Physiotherapy Association) we wrote a short article on "integrating mental health and physiotherapy practice" which disseminated to the physiotherapy membership the fact 1/5 people in Canada experience mental health problems or illnesses, and reinforced the need for physiotherapists to advocate for the individual client, to provide client-centered practice and to incorporate the clients goals recognizing barriers beyond the physical impairment.
- no specific changes made

- continued monitoring of reports of Mental Health Commission and involvement in national interdisciplinary groups such as Mental Health Table
- Open discussions about scope of practice in the work environment discussions with other colleges of psychiatric nursing, professionals and health care receivers to share the learning from the 1.5 days reviewing programs that deal with use of substances and inpatient mental health units
- examined the possibility of developing research projects
- none to date
- I don't work in the mental health field - the forum provided opportunities to include access and broader mental health issues into discussion and policy recommendations for public health
- I continue to work with a number of colleagues from various disciplines to effect change.
- advocacy on these issues
- I have read the report, checked in on the website and have worked with colleagues at my university to enhance their appreciation of the need to address the key learnings above
- Nothing for Canada since I work in the US. The issues are similar and we continue to work on access issues to quality services and supports for all Americans.
- Use better population health data in service planning (as per Accreditation Canada Mental Health Service Standard 1)
- I have shared to conference material with my managers and colleagues, our clinic is restructured to allow quick access to assessment and group programs to ease the wait for consumers.
- sharing of information from forum with members of our Board of Directors
- Worked toward better understanding of client perspectives in service provision and organization.
- work even more dedicatedly towards mental health treatment for all

What actions have you taken following the forum to address your learnings about <u>facilitators</u> or opportunities to enhance access to the biological, psychological and social interventions for Canadians with mental health problems and disorders?

- I am currently working on perhaps getting a youth drop in centre going in my town- because there is just one for all ages of the mental health population. I am in the process of talking to see what I might be able to do to help, as well as getting a depression support group started for youth in the area. I find that if we focus on the youth now then they might not have as many issues as they would in the future. It is all about focusing on the youth of today- they are out future!
- N/A
- Opportunities are tied to barriers. the barriers in 3 above turn into opportunities when solutions are developed. See 3 above.
- I am broadening my knowledge by attending other forums and committee meetings surrounding mental health.
- None

- To discuss the learnings amongst colleagues at Board meetings.
- Nil
- More engagement and formal involvement of consumer voice
- Integration of screening tools into practice. Integration of telephone follow-up service for community.
- In the communication above with our membership we reinforced the need to recognize the potential many of our clients may be living with issues that could impact their treatment goals, effectiveness of treatment and outcomes. The need to better develop our treatment plans and respond appropriately to the clients needs.
- no specific changes made
- On going use of articles and reviewing national documents
- literature review for a research project in this area
- none to date
- Again, to offer access to interventions as an important consideration for further action and policy development.
- I have worked with colleagues to set up a connection with one of the consumers at the Forum - she will be visiting our School and also developing a teaching video for our students concerning her lived experiences. I have also continued to read current literature related to examples of positive initiatives and strategies - government documents, new text book for my discipline
- We continue to work on American health care reform and the implementation of insurance parity - both of which can have significant effects on access.
- Talk (meetings), but "ability to implement" and "political will" remain insurmountable barriers
- None
- enquire about support groups in my community

Did the forum help increase your understanding of issues faced by mental health providers?

Yes	20	51.28%
No	7	17.95%

- I am understanding that that the government and funding have a key role in the determination of services, programs, stigma reduction awareness.... and that it is not easy for change to come as it is about politics.
- waiting lists; coordinating with other services; jurisdictional boundaries impacting the flow of care
- Some of the presentations such as those by the people with mental health disorders or family members highlighted the barriers well. The presentation by Martin Drapeau was helpful in looking at new ways of promoting cooperation among providers. The presentations by the person from the UK placed the issues into a socio/political context.

The presentation by the person for the U.S. made the case for the burden, prevalence etc. The discussions allowed for opportunities to explore issues and to see ones own ideas in a different perspective

- The forum helped me understand how under-resourced mental health facilities are and "labeling" issues, both of which impede interventions.
- appreciated perspectives of other disciplines who presented and were discussants at the tables
- The disconnect amongst the consumer and the health care provider.
- Affirmation
- patient focus is integral
- the silos of services, the challenges with lack of funding as well as access for clients who do not have access to funding, and increased understanding of lack of access in the prison system
- need for greater awareness of addictions
- There was a lot of talk about how to change but really I need to see the evidence that there will be change rather then sitting talking about it. It needed to be more consumer oriented rather then just the panel and then discussions.
- I am a mental health provider, I think I was aware of the issues
- I believe opening up to true collaboration has always been the biggest issue faced by mental health providers.
- Not specifically.
- Some very excellent presentations
- common issues of lack of resources and system issues that impact on satisfaction of providing service.
- familiar with provider problems
- as health provider quite aware

Have you acted on any of the recommendations made throughout the forum?

Yes	11	28.21%
No	12	30.77%

- I continue to be an advocate for stigma reduction and try my best by making a difference with the things I do in regards to mental health I am only one person but there can be a snowball effect.
- Looking for solutions that include but go beyond the predominately biomedical delivery systems.
- Performed interviews to discuss the integrated care model rather than the continuum of care model.
- As able, and where opportunities have arisen

- discussions about stigma, barriers to treatment
- not possible in my current position
- not specifically
- I was not present when recommendations were made
- communicating findings to relevant stakeholders
- made new friends and working with them
- See previous comments concerning involvement of consumers
- Generically as they related to the US system.
- common issues of lack of resources and system issues that impact on satisfaction of providing service.
- Ability to implement is limited
- it is difficult, those who came to the forum have a high interest in making things change and happen ...this is not the rule, in the real world

Did your attendance at the forum influence your practice/work?

Yes	19	48.72%
No	5	12.82%

- It made me more passionate about mental health even more- that I want to make a difference with all the knowledge I have in the field. I want to start to get into the field by volunteering my time to make a difference.
- what I learned at the forum influenced my thinking about my work; implementing changes was not possible, given my current position
- Increased sensitivity to the broader social context and social inclusion issues.
- I am more aware of issues faced by persons with mental health issues and mental health providers.
- expanded my frame of reference based on international experience in Australia
- MBA Thesis pending
- again, mainly affirmation and reinforcement
- Influenced the "eye-opener" communications developed for the membership
- wider awareness of the issues and barriers, making barrier free programs
- research proposals
- it provides data for work I do
- I continue in the same vein as I always have
- Access issues are relevant to US situation
- Raised some consciousness
- Made me more committed to getting a consumer and family perspective on services and practice

- somewhat, looked into including support group in the options offered to the patients...have initiated a research project on making teletherapy available to remote communities awaiting funds

Have you connected with any of the people you met at the forum?

Yes (please tell us with how many and in what way - email, phone, etc.)	14	35.90%
No	10	25.64%

- I have had one email exchange with one person but she did not write back yet. I hope to email her again to see if she needs my expertise.
- 2-3 email
- 10: work, phone, email, in person
- Yes, in ongoing other fora where we collaborate
- Briefly by email to discuss electronic health records research by the Conference Board of Canada.
- about 5 via email, phone or in-person meetings
- by phone, email, face-to-face since I work with two other participants quite closely
- Karen Cohen and the Canadian MHA
- through CAMIMH
- about 6 in person
- through e mail, with two

Have you taken any steps to disseminate what you learned at the forum?

Yes	21	53.85%
No	3	7.69%

- I always make sure that I spread what I have learnt to others. I figure that others need to know about what I have learnt so that people can become aware and spread the word and get it out there.
- sharing ideas/information with colleagues in my profession and with other members of my clinical team

- 1. used examples of patients and family members difficulties, the burden/prevalence data and the socio/political context information in a document and in discussions with colleagues. Used the info from Dr Drapeau in a meeting.
- In my University classroom, during discussions.
- I have shared the experience of a FP provider on reducing wait times in Alberta with several organizations including CMA's Wait Time Alliance
- Sharing with Board Members, Family, and Friends.
- As we advance care models and advocacy, the mental health forum process and its learnings have helped to highlight the interest and energy in this endeavour. It's been reinforcing.
- previously mentioned CONTACT article
- sharing handouts and met to talk with others
- publication in provincial professional journal
- included in our association communications
- advised Board
- Staff meetings
- not specifically but have integrated what i learnt in my practice and research

Please provide with any additional comments you may have about the forum or your attendance at it.

- I would be interested in attending more forums and events in the future. I want to help as much as a possibly can- however perhaps this time it will not be about the politics of mental health as I just do not get that nor know of all the terms that are used. Other then that I really enjoyed being apart of the forum and I hope I am able to be apart of something again in the real near future!
- The forum results need to be disseminated to provincial/territorial government and FPT fora such as the ACHDHR for their edification and to influence the 2014 Accord discussions. The report can be used as part of the rationale supporting documents that provide solutions to be considered by governments individually and collectively.
- I would be happy to attend again.
- The personal stories, such as that of Joe Canada, were most impactful.
- Good forum-- I am in the MH policy area and certainly will try to shape policy to improve access consistent with themes and recommendations from the forum.
- The forum was very well organized, thank you. We are very much looking forward to seeing the draft report after March 17th as the next piece is to see how the information shared at the forum will move forward to influence policy.
- As a health care provider more opportunity to interact with consumers in the small group discussions would have been most interesting to me. As a front line health care provider, I don't feel I have a lot of influence over the funding of services - however I do sit on a

national and a regional committee that permits me some voice - I sat on these committees prior to the forum.

- I would have liked more time for networking - the facilitator could have kept panelists on time a bit better.
- This forum provided an excellent opportunity to learn about the issues, barriers and the actions needed to address mental health access. I recommend that this type of forum by offered to those, like myself, who work in policy areas and also work outside the mental health field. It has greatly increased my understanding of the issues and the tremendous work that is occurring in this field. And it has influenced my work.
- is a final report forthcoming? This would be useful to support dissemination and advocacy
- This was an excellent experience and a model that I hope will be replicated in the future.
- Glad that I was invited to participate. Hope that the US situation added context. Always interesting to see how these issues unfold in another health care system.
- These forums feel great at the time, but inevitably are quite disconnected from the reality of decision-making.
- I have shared the documents that were provided on the USB and via email. It would be good to keep the recommendations circulating some how among the participants so we could here how they are impacting on different areas in Canada.
- It was a useful forum because of the different perspectives and the discussion around that.
- This was an excellent forum, I hope the deciders present acknowledged the reality of the common mental health disorders and how there is a need to work horizontally with different jurisdictions, ministries, agencies, employers, etc.

APPENDIX A

FORUM AGENDA

Forum Agenda: October 5, 2010 - Day 1		
Time	*Activity*	*Speaker(s)*
12:00 – 13:00	Registration *(lunch not provided on Day 1)*	
13:00 – 13:30	Greetings and Prefatory Remarks	o Facilitator, Mr. Bernard Gauthier, Delta Media o Mental Health Table Co-Chair, Dr. Karen Cohen o Parliamentary Secretary, Dr. Colin Carrie o Mental Health Commission of Canada, Vice-Chair, Dr. Fern Stockdale-Winder
13:30 – 14:30	Plenary 1: Client-Centred Care	o Prefatory Remarks by Phil Upshall, Mental Health Commission of Canada, Advisor, Stakeholder Relations o Consumer Panel
14:30 – 15:30	Break-Out Session 1 1. How well are providers meeting the needs of consumers – what works well? What doesn't? 2. How well are systems supporting providers and consumers – what's working? What isn't? 3. What are the gaps and opportunities to better match demand to supply of mental health services and supports? 4. What might be some of the quick and not so quick changes we can make so that services and supports are more client-centered and more accessible?	
15:30- 16:00	Refreshment Break	
16:00 –	Breakout Report Back	

17:00		
17:00 – 18:30	Plenary 2: International Perspectives on How Health Systems Can Facilitate Access to Services and Supports	o David Morris (in person), Professor of Mental Health, Inclusion and Community & Director, Inclusion Institute, International School for Communities, Rights and Inclusion (University of Central Lancashire, U.K.) o Dr. David Shern (in person), President and CEO, Mental Health America (U.S.A.) o Professor Lyn Littlefield (via skype), Executive Director, The Australian Psychological Society
18:30 – 19:30	Dinner and Wrap-Up of Day 1	Facilitator

Agenda: October 6, 2010 - Day 2		
Time	*Activity*	*Speaker*
7:30 – 8:00	Breakfast	
8:00 – 8:05	Welcome to Day 2	Facilitator
8:05 – 8:45	Review of MHCC Strategy Consultation: Feedback around Services and Supports	Dr. Howard Chodos, Special Advisor, Mental Health Strategy, Mental Health Commission of Canada
8:45 – 9:30	Plenary 3: Evidence-Based Mental Health Care	o Dr. Jean Grenier, School of Psychology and Department of Family Medicine, University of Ottawa; Montfort Hospital; Clarence-Rockland Family Health Team o Dr. Marie-Hélène Chomienne, Faculty of Medicine, University of Ottawa and C.T. Lamont Primary Health Care Research Centre, Élisabeth Bruyère Research Institute
9:30 – 9:45	Refreshment Break	
9 :45 – 11:00	Plenary 4: Service Delivery Mix Panel	o Dr. Roger Bland, Professor Emeritus, Department of Psychiatry, University of Alberta o Dr. Sandra Moll, Assistant Professor, School of Rehabilitation Science, McMaster University o Dr. Robert Wedel, Family Physician, Taber, Alberta

		o Dr. Martin Drapeau, Associate Professor of Counselling Psychology and Associate Member in Psychiatry, McGill University
11:00 – 12:00	<u>Break-Out Session 2:</u> 1. What is the match between what evidence says is best practice and what is accessible? Where are the gaps? 2. What are the barriers and opportunities to putting together a team that works? 3. What system change is needed to support the development and functioning of teams and services that deliver evidence-based care? 4. What other kinds of change are necessary in order for the right service from the right provider to reach the right person at the right time in the right place? (e.g. changes to workplace culture and context, changes to provider attitude, client expectation)	
12:00 – 12:45	Networking Lunch	
12:45 – 13:45	Report Back	
13:45 – 14:15	<u>Break-Out Session 3</u>: Next Steps to Addressing Access Issues *(Refreshments provided)*	
14:15 – 15:00	o Mental Health Table Co-Chairs Discussion and Wrap-Up o Draw for Completed Evaluation	Dr. Karen Cohen and Dr. Francine Lemire

APPENDIX B

LIST OF SPEAKERS[§]

Prefatory Greetings

Colin Carrie, B.SC. (HONS.), D.C., Parliamentary Secretary, Government of Canada
Fern Stockdale Winder, Ph.D., Vice-Chair, Mental Health Commission of Canada
Mr. Phil Upshall, Advisor Stakeholder Relations, Mental Health Commission of Canada

Plenary 1: Client-Centred Care (Consumer Panel)

Petey
Mr. Joe Canada
Mr. Chris Summerville
Mr. Michael Villeneuve

Plenary 2: International Perspectives on How Health Systems Can Facilitate Access to Services and Supports

David Shern, Ph.D.
David Morris, Ph.D., BA, CQSW, DASS
Lyn Littlefield, OAM FAPS FAICD FAIM, B.Sc., Dip.Ed., BBSc (Hons), M.Psych., Ph.D.

Plenary 3: Evidence-Based Mental Health Care

Jean Grenier, Ph.D., C. Psych.
Marie-Helene Chomienne, M.D.

Plenary 4: Service Delivery Mix Panel

Roger C. Bland, MB CHB FRCPC FRCPSYCH
Sandra Moll, Ph.D.
Martin Drapeau, M.Ps., Ph.D.
Rob Wedel, BTh, BSc, MD, CCFP, FCFP

Plenary: Review of MHCC Strategy Consultation: Feedback around Services and Supports

Howard Chodos, Ph.D.

[§] Note that speakers' credentials are presented as submitted by them.

APPENDIX C

Speaker Biographies[**]

DR. COLIN CARRIE, B.SC. (HONS.), D.C.

Colin Carrie was first elected to the House of Commons in June 2004 and re-elected January 2006 and October 2008.

In November 2008, he was appointed Parliamentary Secretary to the Minister of Health by The Right Honourable Stephen Harper. In the 39th Parliament, Colin served as the Parliamentary Secretary to the Minister of Industry.

Colin is committed to ensuring that Oshawa's automotive industry remains the pride of Oshawa. When he was elected in 2004, his passion, commitment and knowledge of Canada's auto industry led him to create the first ever Conservative Automotive Caucus, serving as its founding chair.

As Parliamentary Secretary to the Minister of Industry and senior government member of the House of Commons Industry Committee, he spearheaded an unprecedented investigation of the state of Ontario's manufacturing industries, leading the to the landmark report entitled "Manufacturing: "Moving Forward - Rising to the Challenge". Colin was also instrumental in developing the federal government's Auto Action Plan.

During the 38th Parliament, Colin served as a Member of the Standing Committee on Health. He re-introduced Bill C-420, *An Act to Amend the Food and Drugs Act*, and advocated for greater choice in personal health care and natural health products for Canadians.

A graduate of Oshawa's RS McLaughlin CVI, Colin earned a bachelor's degree in kinesiology from the University of Waterloo and later graduated from the Canadian Memorial Chiropractic College as a Doctor of Chiropractic in 1989. Prior to entering Parliament, Colin co-owned and operated one of Durham Region's leading chiropractic and wellness clinics in Oshawa.

Colin is a past executive member of the Durham Chiropractic Society, former chair of Spinal Health Week and former Director of the Oshawa Federal Progressive Conservative Riding Association. He is a strong advocate for autistic children, victims of Hepatitis-C and families affected by Fetal Alcohol Spectrum Disorder (FASD).

Colin has lived in Oshawa for over 30 years. He and his wife Elizabeth have three young children.

[**] Please note that due to anonymity requests on the part of some of the consumer panelists, biographies are not being provided for the consumer panel.

FERN STOCKDALE WINDER, Ph.D.

Recently appointed as Vice Chair of the Board of Directors for the Mental Health Commission of Canada, Fern has been guiding and directing the work of the Commission for over 3 years. She was the Audit and Finance Committee Chair from 2007-2010 and is now the Human Resource Committee Chair and Vice Chair of the Board. She has an in-depth understanding of the work of the Commission and works closely with the management team.

She currently works as a psychologist with the Inpatient Unit in the Rehabilitation and Geriatric Services in Saskatoon City Hospital. She has over 14 years experience working as a clinical psychologist including outpatient rehabilitation, student counselling services, and as Director of Clinical Health Psychology and Professional Leader of Psychology for the Saskatoon Health Region.

Fern holds a PhD in Clinical Psychology from the University of Saskatchewan and completed a Pre-Doctoral Internship at the Nova Scotia Hospital in Dartmouth.

She is a Professional Affiliate with the Psychology Department, University of Saskatchewan and is actively involved in the Canadian Coalition for Seniors Mental Health. She is a Health Professional presenter with the Schizophrenia Society of Saskatchewan, Saskatoon Chapter's Partnership program.

PHIL UPSHALL

Phil Upshall was born in Winnipeg, Manitoba, educated at Dalhousie University, Halifax, (B.Com. 1965) and the University of Toronto (LLB 1967). He was called to the Bar of Ontario in 1969. In 1991, Phil Upshall was diagnosed with bipolar affective disorder. From 1991 to 1995, he dealt with the issues that arose as a result of his illness. Currently, Phil is the Special Advisor on Stakeholder Relations to the Mental Health Commission of Canada and the acting Director of the MHCC's Partners for Mental Health Program, the program which will develop a major mental health social movement.

Phil was a member of the Institute Advisory Board of the Institute of Neurosciences, Mental Health and Addiction and has been a member of a number of expert panels for Stats Canada, Health Canada, CIHI and others. He is the immediate past National Executive Director of the Canadian Alliance on Mental Illness and Mental Health (CAMIMH). Phil managed Mental Illness Awareness Week (MIAW) for 4 years and was the project manager for the Canadian Collaborative Mental Health Initiative, Phase 2.

Phil is the National Executive Director of the Mood Disorders Society of Canada (MDSC), a national NGO with a mandate to represent the interests of consumers and families dealing with depression, bipolar illness and other related mood disorders. MDSC's website contains the extensive consumer based research that MDSC has done on the relationship of bipolar disorder and problem gambling, stigma, wait times for psychiatric patients in the emergency room and matters relating to cultural safety and safe places. He is an adjunct Professor in the Department of Psychiatry, Dalhousie University He is one of the first Board Members appointed

to the Canada Post Foundation on Mental Illness and Mental Health, is a member of the Advisory Board to the Canada Research Chair, National Core for Neuroethics, University of British Columbia.

***Speakers Plenary 2*: International Perspectives on How Health Systems Can Facilitate Access to Services and Supports**

DR. DAVID SHERN (Ph.D.) is the president and CEO of Mental Health America (MHA), after holding several leadership positions in which he helped reengineer mental health care systems in Colorado, New York and Florida and through other national reform efforts. Immediately prior to joining MHA in 2006, Dr. Shern served as dean of the Louis de la Parte Florida Mental Health Institute (FMHI) at the University of South Florida. Dr. Shern has been the principal or co-principal investigator on research projects funded by the National Institute of Mental Health, Substance Abuse & Mental Health Services Administration, Florida Agency for Health Care Administration, Robert Wood Johnson Foundation and the National Alliance on Mental Illness, among others, with support totalling more than $20 million. His research has included studies on the need for community services; the effects of differing organizational, financing and service delivery strategies on continuity of care and client outcome; and the use of alternative service delivery strategies.

PROFESSOR DAVID MORRIS (PhD, BA, CQSW, DASS) is Professor of Mental Health, Inclusion and Community at the International School for Communities, Rights and Inclusion, University of Central Lancashire and Director of the Inclusion Institute, a centre for learning, evidence, innovation and practice on inclusion and community. He also holds a Visiting Academic Associate post at the Institute of Psychiatry, Kings College, London.

Prior to this, David was Director of the cross – government National Social Inclusion Programme (NSIP) at the National Institute for Mental Health in England. Before establishing NSIP in 2004, David worked with the Social Exclusion Unit at the then Office of the Deputy Prime Minister in producing the national report 'Mental Health and Social Exclusion', becoming responsible through NSIP, for implementation of the report's 27 sets of recommendations across government. In this role he has worked with universities, Professional Colleges, primary and specialist mental health services and a wide range of statutory and non-government organisations beyond the mental health sector as well as key UK Government Departments. David also contributed to the work of the Prime Minister's Strategy Unit on inclusion and its Social Exclusion Action Plan (2006) and led delivery of the key action points of that report for employment and mental health, supporting the development by the Cabinet Office of the new cross-government Public Service Agreement on Social Inclusion.

David has had a long - standing professional and post graduate research interest in social inclusion and community engagement. His PhD research programme at the University of Manchester was that of primary care and its role in promoting inclusion in mental health at community level. He has founded, and led a number of partnership - based development programmes in this field, including in 2002-3, the Community and Citizenship Programme at the

Sainsbury Centre for Mental Health and contributed widely, through a range of advisory and consultative roles, programme and journal editorial boards, conferences, research, learning and leadership networks to the development of policy and practice in this field.

Internationally, David has worked to support collaborative learning and development initiatives on inclusion in Europe, the US, New Zealand and Latin America, and most recently by invitation as guest lecture tour speaker in Australia where he presented to a wide range of government and non-government organisations. David is currently working with a World Health Organisation initiative on primary care in the Health Service and Population Research Department of the Institute of Psychiatry, London.

With a professional background in social work and management of Mental Health services in local authority social care, David's career has spanned statutory and voluntary sectors, central and local government, academia, social care and health, where he led on mental health and community services for South Thames Regional Health Authority, subsequently the South East Region of the NHS Executive. He has also held non-executive member or Chair roles in social housing and education organisations. He is a Fellow of the Royal Society of Arts.

PROFESSOR LYN LITTLEFIELD OAM FAPS FAICD FAIM
BSc, DipEd, BBSc(Hons), MPsych, PhD

Lyn Littlefield is the Executive Director of the Australian Psychological Society (APS), the national professional body for psychologists in Australia with over 19,000 members. (There are approximately 24,000 registered psychologists in Australia – the largest mental health workforce.) The APS represents psychologists from both academic and professional service delivery settings across both public and private sectors.

Lyn is currently the Chairperson of the Mental Health Professional's Association which runs the Mental Health Professionals' Network. Lyn is also the Honorary Executive Officer of Allied Health Professions Australia, the national peak body for the major allied health professions - representing over 50,000 health professionals.

Lyn holds an appointment as Professor of Psychology at La Trobe University and was previously the Head of the School of Psychological Science as well as a practising clinical psychologist in community and hospital settings.

Her work in the area of child and family psychology led to the conceptualisation and establishment of the Federal Government's KidsMatter initiative and she is a founding member of the Board of headspace, the National Youth Mental Health initiative.

Importantly, Lyn is currently, or has recently been, a member of a number of Federal Government Ministerial advisory, reference and working groups to do with mental health and health policy, standards, service delivery, and workforce, including the:

- National Advisory Council on Mental Health
- National Advisory Council on Suicide Prevention
- National Primary Health Care Strategy Expert Reference Group
- National Mental Health Workforce Advisory Group
- National Practice Standards for the Mental Health Workforce

Lyn has also had extensive involvement in the development and implementation of the Better Outcomes in Mental Health Care and the Better Access to Mental Health Care - Medicare initiative and is a Board member of the Mental Health Council of Australia.

Speakers Plenary 3: Evidence-Based Mental Health Care

DR. JEAN GRENIER

Dr. Grenier received a PhD from the University of Ottawa in 1999. He is a psychologist, and holds academic appointments at the University of Ottawa as a Clinical professor with the School of Psychology and Assistant professor with the Department of Family Medicine. Dr. Grenier teaches graduate courses in Psychology, namely Cognitive-Behavioral Therapy and Psychology in Primary care. He also teaches Behavioral Medicine to residents in Family Medicine at the Montfort Hospital.

For the past 11 years, Dr. Grenier has been supervising the clinical training of Doctoral students in Psychology.

Two years ago, Dr. Grenier joined the Clarence-Rockland Family Health Team where he oversees their primary mental health program. Recently the Clarence-Rockland Family Health Team became the first Family Health Team to sign a partnership agreement with the University of Ottawa, and serve as a community clinical training site for doctoral candidates in Psychology.

Dr. Grenier's research interests focus on interprofessional collaboration, primary mental health care, and the health of Francophones living in a minority context.

DR. MARIE-HÉLÈNE CHOMIENNE

Dr. Chomienne earned a Doctorate in Medicine at the Université de Paris VI – Pierre et Marie Curie in 1982 and a Masters degree in Epidemiology at the University of Ottawa in 2004. She is a family physician and an epidemiologist, and holds an academic appointment with the University of Ottawa as an Assistant Professor in the Department of Family Medicine.

In 2004, she became a principal scientist at the C.T. Lamont Primary Health Care Research Centre of the Élisabeth Bruyère Research Institute. She currently works at the Montfort Hospital as a family physician-hospitalist with clinical, teaching and research responsibilities.

Dr. Chomienne's research interests are in primary mental health care, determinants of health, and the health status of Francophone minority populations. Dr. Chomienne has also focused

considerably on models of primary care health services, the organization of primary care and improving primary care delivery through interprofessional collaboration.

Speakers Plenary 4: Service Delivery Mix Panel

DR. ROGER C. BLAND (MB CHB FRCPC FRCPSYCH) is Professor Emeritus in the Department of Psychiatry at the University of Alberta and was Chair from 1990 to 2000. His research interests have included psychiatric epidemiology, the long-term outcome of mental disorders, familial distribution of disorders, suicidal behaviors and primary care mental health. He served for many years as a Board member of the Canadian Psychiatric Association and is a currently a member of the CPA/CFPC Collaborative Working Group on Shared Mental Health Care.

He has held a number of administrative positions in mental health with the Government of Alberta, including Assistant Deputy Minister for Mental Health and Medical Director with the Alberta Mental Health Board. He has worked in primary care mental health and currently works with the community crisis intervention program.

DR. SANDRA MOLL has been an occupational therapist for over 22 years. Her clinical work has been primarily in community mental health settings, providing support to individuals with serious mental illness. She recently completed her PhD at the University of Toronto, supported by a CIHR training fellowship for Research in Addictions and Mental Health Policy and Services. Her doctoral research explored the institutional forces shaping the experience of healthcare workers with mental health issues. She is currently a faculty member in the School of Rehabilitation Science at McMaster University.

DR. MARTIN DRAPEAU (M.Ps., Ph.D.) is a Clinical Psychologist, an Associate Professor of Counselling Psychology and of Psychiatry at McGill University. He is a FRSQ Research Scholar and is appointed as Adjunct Professor of Clinical Psychology at the University of Sherbrooke. He is involved in or leads a number of research projects and has published in the area of psychotherapy process and of psychopathology. Dr. Drapeau is also vice president of the Order (College) of Psychologists of Quebec (OPQ) and is on its Board of Directors and Executive Committee. He chairs the committee for continuing education of the OPQ. He was recently elected on the American Psychological Association Council of Representatives and nominated on a number of committees for practice guidelines at the Quebec Agency for the Assessment of Technologies and Modes of Intervention in Health.

DR. ROB WEDEL (BTh, BSc, MD, CCFP, FCFP) has been a family physician in Taber, Alberta for over 30 years, and is the Medical Director for the Chinook Regional Palliative Care Program. He is the Past Physician Lead of the Chinook Primary Care Network, and the Co Chair of Alberta AIM, an Alberta Quality Improvement initiative. He is an Associate Clinical Professor of the Departments of Family Medicine, University of Calgary (U of C) and Alberta. He is a Past National President of the College of Family Physicians of Canada (CFPC), and a Fellow of the College of Family Physicians of Canada. He chairs the Advisory Committee on Family Practice and the History and Narrative Committee of the CFPC. Dr Wedel has recently received the U of

C Faculty of Medicine Award of Excellence in Clinical Research, and the Alberta Heritage Foundation for Medical Research Award for Organizational Vision and Leadership. He is the recipient of the 2010 Alberta Rural Physician Award of Distinction.

Plenary: Review of MHCC Strategy Consultation:
Feedback around Services and Supports

HOWARD CHODOS, PhD, is Special Advisor, Mental Health Strategy, for the Mental Health Commission of Canada (MHCC). Howard was the first person employed by the MHCC and worked closely with former Senator Michael Kirby, the Chair of the MHCC, to get the Commission up and running following its creation by the Government of Canada in March 2007.

Under his leadership, the Commission completed the first phase in the development of a mental health strategy for Canada in November, 2009, with the release of a framework document, *Toward Recovery and Well-Being*. The second phase of this process is now underway and will focus on creating a strategic plan to achieve the seven goals outlined in the framework.

Before joining the Commission, Howard Chodos had been an analyst with the research service of the Library of Parliament since 2000. In that capacity, Howard acted as lead author of the final report on Mental Health, Mental Illness and Addictions by the Senate Social Affairs Committee – *Out of the Shadows at Last* – that recommended the creation of the Mental Health Commission of Canada. Previously, Howard helped to research and write several influential reports by the Senate Social Affairs Committee on the health care system in Canada.

Howard completed his undergraduate studies at York University in Toronto and did his graduate work in Political Science at the University of Manchester, England. He subsequently held a SSHRC post-doctoral fellowship at the School of Public Administration at Carleton University and, in recognition of his contribution to mental health policy in Canada, Howard was appointed Adjunct Professor by the Faculty of Health Sciences at Simon Fraser University.

APPENDIX D

Executive Summary of Presentations

Client-Centered Care
Panelist Presentation:
Chris Summerville

Chris spoke in his capacity as CEO of the Schizophrenia Society, Board member of the Mental Health Commission of Canada, and someone with lived experience, both personally and in his family.

Chris highlighted key needs in providing mental health care. One that needs further addressing is workplace accommodations for people with mental health issues. Another need is safe and affordable housing. He also noted that policy, administrative duties and waiting lists have gotten in the way of clinicians remembering what got them into their work.

Moving forward, Chris noted the importance of moving toward a recovery-oriented system, in which we live in such a way that moves us beyond our limitations. He also noted that we need shared decision-making, that is based on the values of person-centered, autonomy, collaboration, engagement, but that also supports independent access to unbiased evidence-based information on access and interventions.

Patients must be involved and allowed to bring their perspective, goals, vision for their recovery plan; discussions must also address and involve person's family and support system. Lastly, Chris noted that sometimes people are recovering from how they were treated, thereby requiring us to move from a model based on informed consent to one that is based on informed choice.

Client-Centered Care
Panel Presentation:
Joe Canada[††]

Joe Canada began his presentation by providing a background overview to some of the difficulties he experienced up until May 2008. These included: suffering from general dissatisfaction with life, working to please others, succumbing to perfectionist tendencies, taking on too many tasks, pushing himself to the limits on many fronts, and neglecting both himself and his personal relationships.

[††] Joe Canada presented under a pseudonym.

He then provided a timeline of key events in his recovery. In November 2007, he began seeing a psychologist. By May 2008, he burned out completely and a month later, contemplated suicide. Beginning in July 2008, he made steady progress with the support of his psychologist, partner and family physician and through his attendance at group therapy sessions on anxiety and assertiveness. In January 2009, he began developing his return to work (RTW) plan and suffered an anxiety attack in the process; 2-3 months later he resumed working on his RTW plans with an insurance-appointed transition specialist. In June 2009, he began a gradual RTW in his former office and position; at present, he is currently back at work full-time in full-capacity, albeit not in the same Department.

Some of the fundamental life changes that Joe made during his recovery included: overhauling his diet, increasing and improving the quality of his sleep, engaging in regular physical activity, developing different self-perspectives, developing self-awareness and questioning skills, learning to limit his sense of responsibility, gaining a better understanding of anxiety, reducing his reliance on external validation, developing assertiveness, and remaining vigilant for negative feelings or behaviours.

Joe then described his experiences returning to work, which occurred over a six-week period with slow increases in his responsibilities and stress levels. He was extremely concerned with how he would be perceived. Mental health issues were not openly discussed in his work environment. He had a better idea of his limits and was able to assert his need to be accommodated in the workplace. While he re-integrated well with his colleagues, he noted that management was unable or unwilling to engage on the topic. As a result, his relationship with management was never restored to his pre-leave level; the high level of trust and responsibility he had enjoyed was never re-established and he was not given the opportunities to demonstrate his capabilities fully; consequently, he transferred to another department, leaving the work that he loved only six months after his return. He is currently fully engaged and excelling in his new Department. He notes that the primary difference between management in the two departments is knowledge of his leave of absence.

Joe concluded his presentation with a summary of the various reasons for his success. These included: Employee Assistance Program (EAP); short- and long-term disability; secure employment; supportive partner; two good salaries; not having children or ailing parents to support; having access to a psychologist for frequent and regular visits; having access to group therapy sessions; having a supportive family physician; personal determination, commitment, and education; not having any other complicating health issues; having access to a transition specialist for RTW; and having a mandated requirement that his employer accommodate him.

Client-Centered Care
Panel Presentation:
Petey

Below is a re-print of the speech Petey gave at the Forum (rather than an Executive Summary of her speech); it is included here in its full format at her request and with her permission.

My name is Petey. I am 23 years old and I work for the Canadian Association of Elizabeth Fry Societies (CAEFS). I am a student at the University of Ottawa. I am here to speak about mental health services, or lack thereof, in prisons. I have been a "mental health client" since 2006 through the youth and adult systems. Before January 2010, I was diagnosis free. However, at Grand Valley Institution for Women (GVI; a federal penitentiary for women), the psychologist conducting my assessment was told that was for the purpose of parole. She then decided, contrary to her first assessment in 2008, that I should be diagnosed with *Personality Disorder NOS (not otherwise specified).*

I have been convicted of first degree murder. I have accepted responsibility for my crime and I am documented as low risk. My sentence judge even stated that my crime was circumstantial. Despite this, Corrections Services Canada, is convinced that I *must* participate in psychological counseling throughout my entire sentence because "something has to be wrong with me". Therefore, counseling is one of my mandatory parole conditions. If I do not "actively engage" in the counseling, I go back to prison. This order for mandatory counseling is literally coercion, with blatantly violates my rights because no one should be forced to participate in therapy.

When I first arrived at GVI, I requested counseling to try and sort out my horrific past, and my traumatic experiences in the prison system. I was on a waiting list for 7 months, and had to raise hell to get a therapist. After these 7 months, I was assigned to a psychologist. When it became apparent that we were irreconcilably incompatible, I requested a different therapist. Unfortunately, the psychologist to whom I was assigned felt that this was unnecessary, and that I should have no input into who treats me, because I am just a prisoner. It took me another 8 months, along with interventions from the Correctional Investigator and my sentencing judge, before a switch was facilitated. There were absolutely no issues with the second therapist.

It is very important for women in the system to have access to counselors with whom they feel comfortable. It makes no sense to disclose the most intimate secretes of your life, and your feelings, to someone you don't trust. This is especially true when you have lived a life of abuse, as is the case of most women who are sent to prison. The nametag "Doctor" does not make you God. It does not mean that everyone will go along with you. It is not a matter of pride. The focus needs to be the patient. I know women in prison can't expect to be catered to because the system doesn't have the resources for everyone to have the prefect, compatible psychologist; however, the other extreme, as my case, is plain pathetic. During those 8 months of trying to get a different therapist, I did not have counseling. That was not in my best interest, or the interest of rehabilitation.

I am not taking any medication. From the very beginning of my sentence, psychiatrists have been offering me anti-psychotics, anti-depressants, mood stabilizers, anti-epilepsy medication (for insomnia), an anti-anxiety medication. Without a personality disorder diagnosis until 2010 and without one that would clearly benefit from specific medical intervention (such as schizophrenia), offering me serious medication is dangerous. The prison strategy seems to be to medicate me to keep me from freaking out, which has nothing to do with my actual mental state. In fact, it is my experience that prison conditions help create and/or exacerbate existing mental health issues.

Of course I'm going to get depressed when I'm ripped away from my town, and kept from my brother and sister. Wellbutrin or Remerol will not take me back to them.

I was in juvie, or in a "Youth Centre", for nearly two years. If felt like a dumping ground for young people with mental health issues. But this was not a hospital, it was a prison. Staff's focus was on physical control. Being surrounded by girls with severe emotional baggage was scare and traumatizing, mainly because they were children. I used to try to talk them out of slashing. Sometimes it worked, and other times I bandaged their wounds. Seeing what this system does to children who need help left me so frustrated and angry. I used to punch the walls of the prison, rupturing my knuckles against the bricks until the walls were covered with blood. Tegretol and Seroquel would definitely make me stop noticing or caring about these things, but they would not save those children. Neurontin might knock me out, but it won't stop the nightmares.

In 2007, I was involuntarily transferred to Vanier, also known as the "bucket" or the "Milton Hilton". The transfer went against my low risk status. I simply "grew out" of the youth system. I was under 23-hour lock down with a cellmate, and our one hour out was often overlooked because the guards were dealing with an incident somewhere else in the prison. My mattress was on the floor, by the steel toilet. This is where I learned about the "bird bath", which is washing yourself, and your socks and underwear, in the little steel sink in the cell because you can't shower or do laundry for days. At night I couldn't sleep because women were wailing, crying for their children, and banging their heads against their steel cell doors and concrete walls.

My cellmate was clinically deaf and could only communicate through sign language. I had to pick this up fairly quickly to understand her. She was a product of incestuous rape; her father was also her grandfather. I'm not trying to blame her, but this was very difficult for me to handle emotionally after just being transferred from the youth system.

Double bunking in prison is disgusting and traumatizing. No one should have to change their pads and tampons in front of another person. No one should have to defecate two feet away from a stranger. Being in prison should be punishment enough. I really struggled not to give in and ask for something, anything that would help me stop feeling; something to let me sleep.

I have seen first hand how medication affects prisoners. Women would obtain a prescription for meds that they clearly did not need so they could sleep their time away or get high. A number of women I knew use to sell their pills. To me there's a problem when the prison system cannot discern between someone who is taking their prescribed medication and someone who is not.

I was transferred to GVI two weeks after the Ashley Smith tragedy. I was in maximum security for 5 months. Everyone was super sensitive because I was only a year older than Ashley I couldn't move off of the maximum security unit (for example, to go to Healthcare) without the halls being cleared and shut down. I had to be handcuffed, shackled, with two guards at my side. Not because I was dangerous, but because I was new. This type of standard protocol really messed with my head and almost destroyed me. I wasn't dangerous; I was sentenced as low risk, and just came from serving two years *incident free*, so why was I being shackled? Those made me want to fit the label and start reacting. On top of this, maximum security was so lonely. The other women were at least ten years older than I was, so I felt very secluded, which made me even more angry and depressed. Topamax was offered to help "stabilize" my moods, as though low doses of this anti-epileptic medication could stop what was causing these feelings.

When I was finally moved to the general population, I was bunked with a young girl who had serious mental health issues. After two weeks, she violently slashed herself up while I was asleep. There was blood everywhere. I was kicked out of our cell for "investigation" and *my* shaving razors were taken away. My cellmate was then transferred to a psychiatric hospital and I never saw her again. It's a shame that she couldn't have been there *before* her suicide attempt.

I asked to please be moved to a single cell, but instead got another cellmate, who I was told was more "stable". Ten days later, I came back to find out she was in segregation on suicide watch. I was starting to think there was something wrong with *me* because everyone around me was sick of living, and I had no idea how to handle this kind of guilt. Guards in the prison treated these situations as normal, and that I should just get used to it. I couldn't wrap my head around that kind of thinking, so I was left alone, hurt, and confused.

The abuse, oppression, and isolation in prison exacerbate mental anguish, sometime making death seem more inviting.

The prison's solution to all of this? Medication.

Thank you,
Petey

Contact: petey@live.ca

Client-Centered Care
Panel Presentation:
Michael Villeneuve
Accessing Mental Health Care: If I Could Find the Door I'd Knock on It

Michael Villeneuve spoke in the role of caregiver of someone with mental illness rather than as a consumer. In doing so, he presented on his experience and those of his partner in accessing mental health services.

Michael began his presentation by highlighting a basic assumption provided by the Mental Health Commission of Canada: *People living with mental illness have the right to obtain the services and supports they need. They have the right to be treated with the same dignity and respect as we accord everyone struggling to recover from any form of illness.* He then highlighted the role of Local Health Integrated Networks as an important part of the evolution of health care in Ontario, moving from a collection of services that were often uncoordinated to a true health care system.

Michael noted that a key point in his partner's decline was their move to a tiny rural town from a large urban centre that was 35 miles from a tertiary hospital in a large city, and over 40 miles away from a small city. He spoke of his difficulties finding a psychiatrist given that the tertiary hospital was 35 miles from home. During this time, Michael started to advocate and ask questions for his partner. They eventually found a second psychiatrist – 32 miles away from their home. They were told that the wait time for a psychiatric specialty hospital was going to be one year. Eventually his partner had a serious overdose; the difficulty was that the specialty hospital wasn't in their catchment area so they had to go to small-city hospital, where the wait time was 6 hours and he was eventually put on various forms. During this time, a social worker became involved, a distress centre was contacted, and the psychiatrist involved thought his partner needed to find a job. Another social worker told him to go to the ER and make a scene. While they considered it, they didn't do it and eventually Michael's partner had another overdose. At some point in the process, they were offered group therapy which would be available in 3 months, as well as outpatient therapy. Michael's partner took another overdose a few months later.

Following this review of his journey, Michael then provided an overview of various barriers, facilitators and opportunities.

- Barriers included: turf, access hurdles are significant even for those that think they know the system; the lack of an electronic health record that facilitates the travelling of information with someone such that patients do not need to start anew with each and every new health provider; inconsistency among health professionals; and the immeasurable and lifelong toll (in worry) on families and friends.
- Facilitators included: the knowledge of family and friends, which is often greater than that of professionals; family and friends see tiny changes and worrying signs and often want to help; there are beds, organizations and health human resources dedicated to this focus

so that family and friends are not starting from scratch; Mental Health Commission creates a focus and attention on the issue; there is good will among some health professionals

- Opportunities included: EHR and technology; patient-centered care model; a re-imagining of mental health care by courageous, visionary people that is driven by a much more comprehensive, understandable, *integrated* and holistic approach; the need to treat mental health issues like trauma or cancer – organize it and provide care for it like you mean it.

Michael ended his presentation with a dedication to his partner who passed away on March 29, 2009.

International Perspectives on How Health Systems Can Facilitate Access to Services and Supports
Panel Presentation:
Lyn Littlefield
Achieving access to publicly funded psychological services in primary care for Australians

The Burden of Disease and Injury Study in Australia indicates that mental disorders constitute the leading cause of disability. Psychologists have long argued that the Australian population should have government funded access to psychological services for assessment and treatment of mental disorders delivered by appropriately qualified providers and not only the medical profession.

A breakthrough occurred in 2001 when a Federal government initiative called 'Better Outcomes in Mental Health Care' was introduced. Capped funding was provided to the Divisions of General Practice for GPs to refer their patients to psychologists, social workers, and occupational therapists with mental health training. The aim of this initiative was "improving community access to quality primary mental health care" – in other words, to produce better outcomes for consumers with mental health disorders through evidence-based short-term psychological interventions, called Focussed Psychological Strategies (FPS).

Features of the BOMHC were as follows:

- Access to a range of psychological services (ATAPS) was the psychological services component
- GPs who undertook limited training could refer patients with diagnosed mental health disorders (ICD-10 PHC) to psychologists or appropriately trained social workers and occupational therapists
- In order to refer, GPs were required to write a mental health care plan, which included a diagnosis and treatment plan
- Consumers could receive up to 12 individual and/or group sessions of focused psychological strategies (FPS) – primarily cognitive-behavioural therapy – in 2 blocks of 6 sessions that

were punctuated by a GP review; under exceptional circumstances, consumers could receive up to 6 more sessions

Statistics compiled in February 2010 showed that depression and anxiety disorders were the most common diagnoses among consumers at 76% and 57%, respectively. Other diagnoses included alcohol and drug use disorders (7%), unexplained somatic disorders (3%) and psychotic disorders (2%). The severity of presentation was 15% mild, 52% moderate and 33% severe. Data showed positive outcomes of medium to large improvements for approximately 86% of clients with mental disorders.

The uptake of these services was such that demand far exceeded the supply of funding. Based on the success of "Better Outcomes", a new initiative, 'Better Access to Mental Health Care' was developed with the aim of enabling people with diagnosed mental disorders to access assessment and psychological treatment. The funding for this initiative was not capped and uses Medicare rebates for consumers to access psychological services on referral from General Practitioners.

Medicare funded services from psychologists have seen unprecedented demand with over 2 million Australians accessing more than 8 million services since their introduction in November 2006.

Structurally, Medicare is reflected by two sets of items: specialists and generalists.

- Specialists refer to clinical psychologists who are funded to treat patients with more complex and chronic mental health disorders, quite often with co-morbidity of mental health and/or drug and alcohol problems, and are trained to provide comprehensive assessment and complex evidence-based treatment.
- Generalists are registered psychologists, social workers and occupational therapists. They provide focused psychological strategies (FPS), which are mainly cognitive and behavioural techniques.

Availability of Medicare items for accessing psychological services:

- People with a mental health disorder according to the ICD-10 (with a few exclusions)
- Referrals by a GP, psychiatrist and paediatrician. GPs refer under a GP mental health care plan or psychiatric assessment and management plan – or by direct referral from a psychiatrist or paediatrician. GPs do not require specific training to make a referral
- 12 individual sessions per person, per calendar year. A review is conducted after the first 6 session, with a report back to the referrer
- In exceptional circumstances, 6 additional sessions are available
- 12 group therapy sessions (comprised of 6-10 patients) per patient, per year are also available

Uptake of the Better Access initiative and the new Medicare items far exceeded expectations. Over $809 million has gone to GPs for Mental Health Care Plans and allied health providers, mainly psychologists, for evidence-based services. Over 24000 GPs, 3200 clinical psychologists, 12700 registered psychologists, 1200 social workers, and 330 occupational therapists are using the Better Access and Medicare items. Data show that the demand for psychological services is clear and not decreasing.

Despite these positive findings, issues have been raised regarding Better Access, including:

- Medicare items have not been structured for people with low prevalence disorders, or personality disorders, who may need more than (6+6+6) sessions and over a longer period of time
- Medicare does not foster team-based care (workshops involving mental health professionals are building local networks)
- Better Access is more cost-efficient than ATAPS, but the budget blow-out for Better Access is of concern; however, a large number of psychologists bulk-bill health care card holders
- ATAPS and Better Access are complimentary initiatives:
    - Better Access provides a universal cost-efficient service, while ATAPS provides more flexible modes of service delivery

The Australian Psychological Society was extensively involved in these initiatives since the beginning. The APS was also instrumental in the establishment of the Mental Health Professionals' Network that has formed local networks of mental health service providers across Australia, and headspace, the primary care youth mental health services initiative which brings together a wide range of mental health professionals and support service providers in one location for ready access by young people.

In her presentation, Dr. Littlefield also outlined the establishment of the Mental Health Professionals' Network and Headspace. The Mental Health Professionals Association (comprising RANZCP, RACGP, APS & ACMHN) run the MHPN project that provides:

- Inter-disciplinary training and networking
- An environment in which professionals learn to work together based on case discussion
- Increased understanding of each others' roles as mental health professionals
- Peer support, networking and team-building
- Services delivered at local level, plus online support

A $15 million grant was given to roll this out across Australia over 2 years; to date, it has run 1,200 workshops and established 522 networks.

Headspace is integrated, evidence-based, effective services for young people with mental health and substance use problems. It is characterized by being youth friendly and a one stop shop; having a wide range of services and providers; and providing mental health, drug and alcohol, health, support (housing, employment, education). It was provided with $54 million over 4 years to establish 30 sites. It consists of a Consortium comprised of 4 partners and 4

components [Centre of Excellence, Education and Training, Community Awareness, plus the Youth Services (major portion of funding)]. It received expansion funding in the amount of $78 million for 30 more services to be established over 2010 – 13.

Dr. Littlefield ended her presentation with a discussion of the future of government funded psychological services in the community in the context of the major health reform agenda of the Australian Federal government.

International Perspectives on How Health Systems Can Facilitate Access to Services and Supports
Panel Presentation:
David Morris
Access to Services and Social Inclusion

Dr. Morris' presentation considered how a policy and practice for social inclusion can support improved access to services and through this to recovery-oriented opportunities in mainstream community settings.

Based on the UK's recent experience of developing and implementing a national programme on social inclusion, the presentation proposed that accessible multi-professional services operating through forms of community partnership were essential to the achievement of user determined goals and effective inclusion outcomes.

A cross-government approach to inclusion policy was described in the context of a brief overview of the mental health policy context. The work of the National Social Inclusion Programme in leading implementation of the policy was summarized with a focus on the key dimensions of professional culture and innovative leadership.

In his presentation, Dr. Morris emphasized the importance of a community engagement strategy to people with established mental health problems as well as to broader population health objectives. Engaging communities is so important to access because it:

- promotes opportunities for civic engagement and mainstream participation
- catalyses supportive social networks ('Connected Communities')
- promotes reduced stigma and discrimination through public involvement
- drives inclusion by situating it in the context of community well-being
- potentiates the value and central role of professional and clinical services through supportive alliances and partnership–services as *social movement*

He also provided an update in the context of the new Coalition government's policies, including that of the 'Big Society'. To be effective, policy needs to:

- build on previous policy on citizen and community empowerment;

- be sophisticated enough to reflect the complexities and contradictions, especially the relationship between democratisation/empowerment and social capital/networks; and
- address the challenge of inclusion through civic participation in people to whom it is systemically denied.

Dr. Morris proposed that effective, integrated professional services can and should serve to enable this strategy and that the engagement of communities is no substitute for innovative and comprehensive public services.

International Perspectives on How Health Systems Can Facilitate Access to Services and Supports
Panel Presentation:
David Shern
Mental Health in the United States : Historical Perspectives and Current Opportunities

Dr. Shern began his presentation by providing an overview of Mental Health America and a historical overview of the mental health system in the U.S. He then provided data on access to care, quality of care for people diagnosed with a serious mental illness (i.e., percentage with any treatment, with minimally adequate treatment, and without minimally adequate treatment), 12-month prevalence of mental health conditions internationally (U.S. had the highest prevalence at just under 30%), and prevalence of mental health disorders within the U.S.

The following are key data points presented by Dr. Shern:

- while half of all people with a mental health diagnosis experience it by age 14, many won't receive treatment until age 24. This has implications both in the short-term and long-term in terms of future workforce and market competitiveness.
- Over 30,000 lives are lost to suicide in the U.S. annually.
- Mental health conditions account for over 20% of illness-related disability in the U.S.
- In 2002, serious mental health conditions were associated with $193.2 billion in lost earnings per year.
- People with severe mental illness have a shortened life expectancy
- Numerous examples of increases in costs, greater problems with care management and poor outcomes among people with co-morbid conditions, such as cardiac disease and depression

Dr. Shern also spoke to Mental Health America's approach, highlighting the following:

- U.S. has the most expensive health care system in the world with poor outcomes
- Chronic illnesses account for 75% of health care expenditures
- U.S. does not effectively prevent or treat chronic illnesses
- Controlling health care costs and improving population health status will require effective treatment of mental health disorders

Moving forward, Dr. Shern noted that improving health status and controlling costs will require an integrated treatment of multiple chronic conditions, in which behavioural health services are essential. He also noted the need for much greater emphasis on prevention and early detection/intervention. Within this context, he concluded his presentation by discussing issues related to parity in group health plans, the Patient Protection and Affordable Care Act and the likely impact of these on mental health care in the United States.

Review of MHCC Strategy Consultation
Presenter:
Howard Chodos

Dr. Chodos began his presentation with an overview of the mandate of the MHCC, emphasizing that the MHCC is not involved in service delivery or monitoring, but rather is a catalyst for mental health system transformation. Dr. Chodos reinforced the need for transformation by highlighting the fact that only one-third of people who need mental health services in Canada actually receive them.

Dr. Chodos highlighted that a mental health strategy for Canada can set a vision for a transformed system that includes: stating an overarching vision and goals; developing strategic directions and suggesting actions to realize the vision and goals; proposing benchmarks and targets; identifying examples of successful models and practices that are consistent with the vision; and building consensus across diverse sectors and stakeholders.

Achieving a mental health strategy for Canada is a two phase process that involves setting the vision for what to achieve, and then establishing how to achieve the vision. The goals of a transformed mental health system are as follows:

- Founded on recovery and well-being for all
- Incorporates promotion and prevention
- Responsive to diverse needs
- Recognizes and supports the role of families
- Reduces inequities and barriers to access
- Promotes seamless integration around needs
- Is based on knowledge from multiple sources
- Strives to create a society that is inclusive

Dr. Chodos noted that Goal 5 of the strategy is specifically devoted to access and integration. This goal stipulates that people of all ages have timely access to appropriate and effective programs, treatments, services and supports that are seamlessly integrated around their needs. Specifics of such a goal include:

- Every door leads to service – no wrong door
- Coordinated across the lifespan

- Integrated at the point of delivery
- Community-based services close to the people served – and connected with other systems (justice, police, education, social services, etc.)
- Least intrusive and least restrictive
- Full range of services from promotion, prevention, early intervention to more intensive services.

Evidence-based Mental Health Care Presentation:
Jean Grenier and Marie-Hélène Chomienne
Evidence-based Mental Health Care

- Financial access to non-physician mental health providers and medication – remove inherent bias toward medications
- Genuine choice no matter what one's income level.

"What other kinds of change are necessary in order for the right service from the right provider to reach the right person in the right time at the right place?" Change must be seen in all goals of the strategy to address access and integration including:

- Recovery/well-being
  - Developing genuine partnerships between providers and users of services
- Prevention/promotion
  - Integrating prevention and promotion in order to reduce demand for services
- Diverse needs
  - Enabling providers to acquire the cultural competency to meet the diverse needs of the Canadian population
- Families
  - Better integrating formal services with informal care and support
- Research/knowledge
  - Enhancing knowledge transfer to make use of best available knowledge
- Inclusion
  - Reducing barriers to people seeking and accessing treatments, services and supports

Drs. Grenier and Chomienne co-presented this session. Evidence-based medicine is an integrative decision making process that is patient-focused, taking into consideration the clinical data, patient values and the best evidence available. Levels of evidence go from expert opinion and increase in quality of evidence to case-controlled studies, cohort studies, randomized control trials (RCTs), critically appraised individual articles, critically appraised topics, and systematic reviews.

Evidence-based practice is premised on both individual clinical expertise and the best available external evidence. It can be reflected in many ways, including more effective and efficient assessment & diagnosis, as well as identification & consideration of individual patients' context,

rights, and preferences in making clinical decisions about their care. Throughout this, the importance of proper diagnosis cannot be stated enough.

Current evidence indicates that there are many disorders among adults for which there are one or more evidence-based psychological treatments (e.g. mood disorders, eating disorders, anxiety disorders, personality disorders – to name a few).

Several patterns emerge in the evidence for severe mental illnesses (i.e., schizophrenia, psychotic disorders), including:

- Medications are superior to psychosocial treatments alone in most severe mental disorders
- Combined treatments (medication plus psychosocial interventions) often produce the best results
- Some psychotherapies are empirically supported, particularly cognitive-behavioural therapy (CBT)
- Other psychosocial treatments (e.g., family education) and services (e.g., Assertive Community Treatment - ACT) are evidence-based

There are evidence-based pharmacological treatments for almost all common mental health problems; there are also evidence-based psychological treatments for almost all commonly encountered mental health problems.

There is an abundance of literature that demonstrating the cost-effectiveness and cost-offsets of evidence-based psychological treatments. Despite this, there are a number of barriers to evidence-based psychological treatments, including:

- Lack of public knowledge regarding the existence of evidence-based psychological treatments
- Stigmatization of mental health
- Lack of mental health professionals appropriately trained in evidence-based psychological treatments
- Most psychologists are trained in evidence-based psychological treatments as part of their core curriculum, but work essentially in the private sector
- Lack of consumer choice in selecting the preferred optimal treatment
- Professional culture & attitude
- When it comes to psychotherapy, service delivery is not really patient-oriented… rarely are patients offered any choice
- System disincentives (i.e., our health system does not encourage enough cost-effective service delivery)

Drs. Grenier and Chomienne also spoke to the importance and value of integrating mental health care into primary care, particularly given the fact that the majority of mental health care is provided within general primary care services. Primary health care (PHC) is an important

setting in which to introduce treatment and care for people with mental disorders for numerous reasons, including:

- helps to reduce the stigma associated with stand-alone mental health services
- facilitates early identification and treatment of such disorders and thus reduces disability
- increases the possibility of providing care in the community and the opportunities for community involvement in care
- improves access to mental health care among underserved populations

What does an integrated primary health care team look like? At least one health professional with each of the following skill sets should ideally be part of the core team:

- excellent knowledge in medicine, diagnosis and skills to prescribe medication
- solid skills in providing counselling services, crisis intervention, coaching, education, case management, low-intensity evidence-based psychotherapy as well as navigation through community services
- skills in performing differential diagnosis of mental problems and advanced knowledge/skills in providing psychological treatments; skills to provide on-site consultation for complex cases and training/guidance in conducting psychotherapy with single & multiple diagnoses
- advanced knowledge and skills in psychopharmacology and severe psychopathology, perhaps on consultation basis
- advanced knowledge and skills in psychopharmacology and severe psychopathology, perhaps on consultation basis
- advanced knowledge in pharmaceuticals, perhaps on consultation basis

Drs. Grenier and Chomienne concluded their presentation with a look at various opportunities moving forward. These include:

- Ongoing primary care reform is perfect timing
- Interdisciplinary teams and clinics are on the rise, highlighting the need for teams that contain the right skill sets and a balance of them
- The time is appropriate to make evidence-based assessment and treatment services a universal requirement for publicly funded mental health care
- Measurement of performance and clinical outcomes
- Consider establishing appropriate training curricula with board certification for varying levels of therapist skills in conducting evidence-based psychological treatments. Such training could ideally include not just seminars and readings but X number of hours of supervised practice (i.e., video recordings of treatment sessions with consenting patients)
- Within the spirit of patient-centeredness, our health care system should be respecting patients' values, rights and preferences, to make informed choices about their mental health treatment

- Include mental health evidence-based treatments as system incentives for cost-effective management
- Explore possibilities of better linkages between the public and private sectors

Service Delivery Mix
Panel Presentation:
Roger Bland

Dr. Bland's presentation provided a brief review and classification of some of the types of evidence available.

He presented some well established data. Specifically, treatment works, showing a reduction in morbidity; however, there is a major treatment gap (many who could benefit from treatment don't get it). Collaborative care makes a difference and Assertive Community Treatment teams can improve outcomes for those with severe and persistent mental illness (SPMI). Crisis intervention and diversion programs can work and reduce justice system involvement.

Dr. Bland looked at the question of whether deinstitutionalization failed, focusing on the effects on homelessness, justice systems and poverty of the mentally ill. The system is frequently failing to provide adequate timely access, assessment, treatment and follow up.

Dr. Bland also examined some of the reasons for the present dissatisfaction or unsatisfactory performance. These include:

- greater public awareness and acceptance leading to increased demand
- Deinstitutionalization has increased service demands
- Many more skilled service providers are needed
- Stigma is still an obstacle
- Lack of funding is problematic
- Mental health has not been a priority.
- Political interference and constant meddling without long term goals and so called 'pilot projects' that are not sustainable leads to inconsistent services.
- Administrative incompetence and unnecessary bureaucracy.
- Poor communication with user groups and providers.
- Failure of training programs to prepare for new realities.

In his presentation, Dr. Bland noted that possible remedial steps include:

- re-orienting the professions and their training programs to a public health and population health focus – support primary care but don't do it in the mental health system.
- Get the supports that the SPMI need in place, with dignity and respect.

- Support collaborative care endeavors.
- Get more children's services through the schools.
- Vastly improve management.
- Set system performance standards e.g. wait times. Support advocacy efforts.
- Do the things that work - close the treatment gap.

Service Delivery Mix
Panel Presentation:
Robert Wedel

Dr. Wedel spoke from the perspective of a family physician in Alberta. He noted various challenges in the treatment of mental health issues, including the fact that major depressive disorder is still largely untreated. In addition, of all patients with MDD in last 12 months:

- 49% did not receive any treatment
- 52 % received some treatment
- 58% received inadequate treatment
- 42% received at least minimally adequate treatment
- Only 22% received adequate treatment.

Dr. Wedel's presentation focused on the shortcomings in the way care is organized and the consequential problems this produces in quality care – quality problems do not typically occur because of failure of good will, knowledge, effort, or resources that are directed to health care.

Dr. Wedel presented the core elements of a care model that is focused on functional and clinical outcomes that include an informed, activated patient and a prepared, proactive practice team. Elements of such a model include:

- the establishment of **registries** supported by information technology
- Improved **capacity and continuity** in order to improve access
- Organizational changes that support the **integration of regional and community services** with Family Practice clinics/groups
- The establishment of **teams** with individuals whose role includes **care co-ordination** (coordinating and facilitating - including system navigation)
- A greater emphasis on **self-management.**

Data was presented showing there is strongest evidence for primary care improvement for delivery system redesign within primary care. This facilitates enhanced access through redesign of scheduling and enhanced quality of care through interventions that re-shape multidisciplinary team-based care. There is also strong evidence for self-management, if integrated into the 'regular care' provided within the trusted relationship of a medical home.

Dr. Wedel then provided an overview of various barriers to access, which included:

1. Access to family physicians and mental health professionals
2. Access to proactive surveillance of patients, effective support for self management, sharing of relevant information among providers
3. Access to specialized services (i.e., acquiring/developing the matrix of community supports to patients)

As part of this discussion, Dr. Wedel discussed two ways to improve clinical care using teams: 1) pre-planning and standardizing care provided by the team; and 2) embedding clinical protocols and guidelines to assist the team and reduce variations in practice. The first element involves, for each physician's panel of patients, identifying patients with targeted conditions; identifying the screening and prevention needs for a specific patient population; identifying complex patients for case-management; and health screening, prevention, and ongoing management of chronic diseases.

Dr. Wedel concluded his presentation by presenting some solutions to the treatment of depression in family practice. These solutions include practice management and treatment issues (e.g. screening and measurement tools, guidelines and protocols, reminder systems) and healthcare system issues (e.g., health coaches, family practice nurse, psychiatric nurses, nurse practitioners, and self-management resources).

Service Delivery Mix
Panel Presentation:
Martin Drapeau
What is "right"?

Dr. Drapeau began his presentation with an overview of the World Health Organization's service organization pyramid for an optimal mix of services for mental health. This model looks at the frequency of need, costs, and the quantity of services needed.

He then reviewed and commented on a number of definitions for evidence-based practice, highlighting their strengths and weaknesses, as offered by:

- **Wikipedia:**
  The term evidence-based practice (EBP) **or** empirically-supported treatment (EST) refers to preferential use of mental and behavioural health interventions for which systematic empirical research has provided evidence of statistically significant effectiveness as treatments for specific problems
- **The Institute of Medicine:**
  Evidence-based practice is the integration of best research evidence with clinical expertise and patient values.
- **The American Psychological Association:**
  Evidence-based practice in psychology (EBPP) is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences.

As part of this, Dr. Drapeau reviewed the various elements of evidence-based practice that lead to a treatment plan – these include:

- empirically supported treatments
- culture
- guidelines
- principles of change
- clinical judgment and expertise
- personality and other patient variables
- patient preferences

Dr. Drapeau proposed that evidence-based practice is a concept that goes beyond simply referring to empirically supported treatments, to also include evidence derived from research on therapist-patient relationships and dynamics, common factors, therapist traits and principles of changes, and treatment by aptitude interactions, amongst others.

Dr. Drapeau's presentation concluded with an elaboration of the forum's quote regarding access.
The right service for the right person from the right provider in the right time at the right place… in the right conditions for the right problem and targeting the right "construct" assessed with the right indicators by the right assessor using the right methods, and treated with the right principles based on the right evidence, and so on and so forth…

Indeed, to date, there is no evidence that matching a treatment type to a diagnosis is the best way to proceed.

Service Delivery Mix
Panel Presentation:
Sandra Moll
An Occupational Therapy perspective on providing the right services to the right people in the right places

In beginning her presentation, Dr. Moll focused on the "right services" by emphasizing the need to shift from illness to recovery-oriented services; the need to recognize the importance of meaningful community participation to overall health and well-being; and the need to ensure that people's occupational needs are addressed.

In terms of the "right people", Dr. Moll focused on high risk groups such as children & youth, First Nations communities & new immigrants, individuals with severe mental illness, and seniors. These groups highlight that the mental health and addiction system needs to reach everyone who may need help, rather than solely those individuals who reach services.

Services in the “right places” refers to support for family physicians in primary health care settings; supports in schools, workplaces and homes; building creatively on natural supports; coordinating resources; and utilizing technology.

Dr. Moll concluded her presentation with discussion of a model for coordinating mental health supports and services. This model, which situates people with mental health and addictions issues at its core, considers the determinants of health (i.e., employment, income, medical care, education, housing, social/leisure, and care for self and others). These determinants are in turn surrounded by supports and services such as disability support services, workplaces, family doctors and family health teams, schools, housing, supported housing and shelters, nursing homes, community groups and services, peer supports and self-help, and family/caregivers.

APPENDIX E

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(as of October 7, 2010)

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APPENDIX F

Descriptions of 12 Mental Health Table Association Members

CANADIAN PSYCHOLOGICAL ASSOCIATION *(Mental Health Table co-Chair)*
The Canadian Psychological Association (CPA) is the national professional association of psychologists in Canada whose mandate is to promote excellence in the science, teaching and practice of psychology and to contribute to the health and well-being of Canadians. There are approximately 16,000 regulated psychologists in Canada though the CPA represents the interests and activities of the scientists as well as the regulated practitioners among our discipline. Psychologists represent Canada's largest regulated group of specialized mental health care providers.

Relying on the scientific method to develop an understanding of how we think, feel and behave, psychologists apply their knowledge to help people understand, explain and change their behaviour. Psychologists, researchers and practitioners alike, work in many sectors and settings including government departments and organizations, school systems, universities, hospitals and clinics, correctional facilities, industry and private offices. Some examples of the kinds of problems which psychologists study and/or for which they carry out health service include:

- mental health problems such as depression, anxiety, phobias, etc.;
- psychological determinants of health and psychological factors that contribute to health and disease management;
- brain injury, degenerative brain diseases;
- cognitive functions such as learning, memory, problem solving, intellectual ability and performance;
- criminal behaviour and crime prevention;
- addictions and substance use and abuse;
- stress, anger and other aspects of lifestyle management;
- psychological factors in the workplace, in sport, in recreation (e.g. motivation, leadership, productivity, healthy workplace)
- marital and family relationships

THE COLLEGE OF FAMILY PHYSICIANS OF CANADA *(Mental Health Table co-Chair)*
The College of Family Physicians of Canada (CFPC) is the voice of family medicine in Canada. Representing more than 25,000 members across the country and abroad, the CFPC is the professional organization responsible for establishing standards for the training, certification and lifelong education of family physicians and for advocating on behalf of the specialty of family medicine, family physicians and their patients. The CFPC accredits postgraduate family medicine training in Canada's 17 medical schools including Enhanced Skills and Third Year Residency programs.

The CFPC creates and administers the examinations leading to Certification in Family Medicine, and the Certificate of Special Competence in Emergency Medicine. Family physicians who

uphold the CCFP designation must maintain it by meeting the requirements for maintenance of Certification set by the College.

The CFPC supports every Canadian in every community having access to a family doctor who works collaboratively as part of a team.

CFPC members belong to one of ten provincial Chapters which become involved in local healthcare activities. Many members serve on national and/or provincial committees, task forces and work groups to help advance family medicine policy, programs, education, research, advocacy and health care to patients.

CANADIAN ASSOCIATION OF OCCUPATIONAL THERAPISTS

The Canadian Association of Occupational Therapists (CAOT) is a national professional association that represents over 12,000 occupational therapists in Canada. CAOT also has a network of provincial and territorial occupational therapy voluntary organizations as affiliate members. CAOT is a non-profit organization that provides advocacy, resources and member services to promote excellence in occupational therapy. As part of our Association's strategic priorities, CAOT seeks to create an evidence-based environment for occupational therapy, promote workforce capacity, foster partnerships and alliances and advocate for access to occupational therapy.

CANADIAN ASSOCIATION OF SOCIAL WORKERS

As a federation of nine provincial and one territorial social work organizations, the Canadian Association of Social Workers (CASW) represents over 17,000 social workers and provides a national leadership role in strengthening and advancing the social work profession in Canada.

Social work is a profession that promotes social changes aimed at improving conditions that affect the health and well-being of individuals, families, groups and communities; they provide counselling, therapy and problem-solving interventions to create functional relationships between the system and those who interact with it. The uniqueness of social work practice is in the blend of some particular values, knowledge and skills, including the use of relationship as the basis of all interventions and respect for the client's choice and involvement.

Social workers work in a variety of settings including hospitals, community health centres, mental-health clinics, schools, advocacy organizations, government departments, social service agencies, child-welfare settings, family-service agencies, correctional facilities, social housing organizations, family courts, employee-assistance and private counselling programs, school boards and consultation agencies. In all provinces there is social work regulation and in most of them social workers must meet regulatory requirements to practice.

CANADIAN ASSOCIATION OF SPEECH-LANGUAGE PATHOLOGISTS AND AUDIOLOGISTS

With more than 5,500 members, the Canadian Association of Speech-Language Pathologists and Audiologists (CASLPA) is the single national professional association that supports the needs, interests and development of speech-language pathologists, audiologists and supportive

personnel across Canada. Through this support, CASLPA champions the needs of people with communications disorders.

CASLPA offers various membership categories as well as certification for its members. Membership is available to individuals who are graduates of Canadian University Programs of audiology or speech language pathology or graduates of non-Canadian programs judged to be equivalent. One of the key result areas in our strategic plan is to “Enhance the context of working life for members to improve service provision and access.” One of the key objectives relates to working conditions and well-being of members.

CANADIAN FEDERATION OF MENTAL HEALTH NURSES (CFMHN)

The Canadian Federation of Mental Health Nurses (CFMHN) is a national voice for psychiatric and mental health (PMH) nursing in Canada. It is an associate group of the Canadian Nurses' Association (CNA), for which it provides expertise for the specialty in matters relating to mental health nursing. CFMHN's membership of over 1000 nurses work in a variety of settings that provide mental health nursing intervention to individuals, families, and communities . Although most CFMHN members are registered nurses, other designations of nurses are also welcome.

CFMHN's primary objectives are to assure national leadership in the development and application of nursing standards that inform and affect psychiatric and mental health nursing practice; examine and influence government policy, and address national issues related to mental health and mental illness; communicate and collaborate with national and international groups that share professional interests; and, facilitate excellence in psychiatric and mental health nursing by providing members with educational and networking resources and opportunities.

Part of the Federation's aim to advance PMH nursing in Canada involves a strategic communications strategy comprised of an interactive website, quarterly newsletter, networking opportunities, and involvement at conferences and on national committees such as the Canadian Alliance on Mental Illness and Mental Health (CAMIMH) and Canada's Mental Health Commission.

The CFMHN hosts a national conference every other year providing opportunity for PMH nurses to come together from across Canada, sharing news, updates, research, experience, and a wealth of knowledge over several days of conferencing and networking.

The Federation was formed in 1988 and pioneered national credentialing in PMH nursing. It achieved CNA certification status seven years later. As a result of the Federation's efforts, nurses across the country can quality for the national psychiatric and mental health nursing credential; and, nurses with certification are eligible to use the CPMHN(C) designation after their names and wear the official CAN certification pin -- a sign of professional achievement.

The PMH certification exam has the highest number of completers out of all certification exams offered by CNA. CFMHN advocates for core competencies in undergraduate programs that promote the inclusion of mental health education in basic nursing education.

CFMHN's administrative office is located in Toronto, ON. The Board of Directors has representatives from each province and territory. Regular board meetings are held by teleconference and in-person when possible.

As a national voice for the specialty of mental health nursing, the CFMHN prides itself in delivering on the goals set by the membership with national specialty certification; national standards of practice, and national core competencies as key achievements. Join us and become part of the voice.

CANADIAN MEDICAL ASSOCIATION

The Canadian Medical Association (CMA) is a national voluntary professional association that comprises 70,000 physician members. The CMA Vision statement is "a healthy population and a vibrant medical profession". One of the five key result areas of the CMA's current 5-year strategic plan is "healthy physicians", and a key outcome in this area is to achieve improved physical and mental health of physician members. This is being primarily carried out through the CMA Centre for Physician Health and Well-being, which was established in 2003 for the purpose of assisting Canadian physicians to attain and sustain their optimal level of personal health and well-being. In 2007, the CMA co-sponsored and collaborated in the development and execution of the first-ever comprehensive survey of Canadian physicians' mental and physical health, the results of which have just been published (see Frank E and Segura C in Can Fam Physician 2009;55:810--1.e1-7). This survey did include some questions that were asked in the recent major survey of nurses' health in Canada. The CMA would be very interested in participating in the development of a common survey instrument that could be used to compare results across health disciplines in a variety of practice settings.

CANADIAN NURSES ASSOCIATION

The Canadian Nurses Association (CNA) is a federation of 11 provincial and territorial nurses' associations and colleges representing more than 136,200 registered nurses and nurse practitioners.

CNA is the national professional voice of registered nurses, supporting them in their practice and advocating for healthy public policy and a quality, publicly funded, not-for-profit health system.

CNA speaks for Canadian registered nurses and represents Canadian nursing to other organizations and to government nationally and internationally. It gives registered nurses a strong national association through which they can support each other and speak with a powerful, unified voice.

CNA's Objects

The objects of CNA as defined in the Letters Patent (1996 revision) are:

- To promote high standards of nursing practice, education, research and administration in order to achieve quality nursing care in the public interest.
- To promote uniform and high quality regulatory practices in the public interest and in collaboration with nursing regulatory bodies.
- To act in the public interest for Canadian nursing and nurses, providing national and international leadership in nursing and health issues.

CNA's Vision

Registered nurses: leaders and partners working to advance health for all.

CNA's Mission

CNA is the national professional voice of Registered Nurses, supporting them in their practice and advocating for healthy public policy and a quality, publicly funded, not-for-profit health system.

In pursuit of its vision and mission, CNA has established the following goals:

- CNA advances the discipline of nursing in the interest of the public.
- CNA advocates public policy that incorporates the principles of primary health care (access, interdisciplinary practice, patient and community involvement, health promotion including determinants of health and appropriate technology/roles/models) and respects the principles, conditions and spirit of the Canada Health Act.
- CNA advances the regulation of registered nurses in the interest of the public.
- CNA works in collaboration with nurses, other health-care providers, health system stakeholders and the public to achieve and sustain quality practice environments and positive client outcomes.
- CNA advances health policy and development, in Canada and abroad, to support global health and equity.
- CNA promotes awareness of the nursing profession so that the roles and expertise of registered nurses are understood, respected and optimized within the health system.

CANADIAN PHARMACISTS ASSOCIATION

The Canadian Pharmacists Association advocates for pharmacists and supports its members to advance the profession and enhance patient outcomes. Through our activities, CPhA will continue to provide pharmacists with the tools, information and leadership they need to protect the health and safety of Canadians.

CANADIAN PHYSIOTHERAPY ASSOCIATION

The Canadian Physiotherapy Association (CPA) is the national voluntary professional association for physiotherapy in Canada and represents over 10000 members. CPA's mission is 'to advance the profession of physiotherapy in order to improve the health of Canadians'. CPA promotes excellence in the practice of physiotherapy and supports evidence informed practice and knowledge translation in all practice areas.

CPA has 11 provincial Branches, 14 clinical Divisions and two assemblies. CPA's national office delivers pan-Canadian programs and services. Its Branches manage professional relations and service at the provincial level while the Divisions support professional development and networking in specific clinical practice area; the assemblies serve specific member groups including support personnel and students.

CANADIAN PSYCHIATRIC ASSOCIATION

Our Mission

As the national voice of Canadian psychiatrists, the Canadian Psychiatric Association advocates for the professional needs of its members and promotes excellence in education, research, and clinical practice.

Our Vision

A strong profession for a healthy population.

Objectives of the Association

- To uphold and develop the bio-psychosocial approach to the practice of psychiatry and promote research and continuing education of members by establishing and maintaining standards of practice and facilitating maintenance of competence in the practice of general and specialized psychiatry
- To promote and participate in educational programs necessary for the care of persons with psychiatric disorders and the promotion of mental health
- To represent the profession of psychiatry to governments, universities, medical associations, licensing and certifying bodies, and other organizations with which the psychiatrists of Canada from time to time may have relationships
- To publish journals, newsletters and other literature for the dissemination of knowledge regarding psychiatric disorders and promotion of mental health

REGISTERED PSYCHIATRIC NURSES OF CANADA

The Registered Psychiatric Nurses of Canada (RPNC) provides a unified provincial, national and international voice for Canadian Registered Psychiatric Nurses with a vision to provide quality mental health services for all Canadians.

RPNs represent the single largest group of health care professionals in the mental health field in Western Canada. RPNs are on the front lines, working as key members in an interdisciplinary team of health care professionals. They provide care and services in hospitals, facilities and communities, and are at the heart of care delivery to patients.

RPNs work in full partnership with psychiatrists, psychologists, registered nurses, occupational therapists, social workers, pharmacists, managers, community agencies, law enforcement professionals and social service providers.

APPENDIX G

WORKING GROUP DISCUSSIONS
BREAK OUT SESSION 1

QUESTION 1: How well are <u>providers</u> meeting the needs of consumers? What works well? What doesn't?

1. What works well?

i. Availability of different personnel

1. In Alberta, psychiatric nurse on call is available to triage then refer to psychiatrist
2. UK established care managers

ii. Trained health providers

- When you obtain a good provider, clients do well

i. Effectiveness of community mental health organizations.

- They do a good job with what they have got to work with

2. What doesn't work?

i. Lack of voice for consumers

ii. Lack of coordination and collaboration within the system

- Too much reliance on emergency departments
- No one door that one can access
- Need more entry points
- When a person does get in there is no coordination among the systems
- Need for an electronic health record
- Need to support communication between community services and supports and in-patient mental health
- Users need help in navigating the system and helped to discern what they need and when
- System is stretched to its limit
- Providers work in isolation
- System is very referral-oriented

iii. Lack of processes, services and health providers available for persons with mental illness (unlike for persons with physical problems)

- Other than a psychiatrist, who else can consumers access within the funded system?
- Particular gap is in follow-up care
- Need different systems and professionals for different kinds of mental illnesses
- System needs improving as relates to children
- Need for outreach services
- Providers as a group have difficulty meeting the needs of consumers b/c of lack of human resources and organizational resources
- Need to differentiate between provider of care, provider of service, and provider of resources. For example, what might appear to be a provider of care issue (i.e. an issue related to a particular health professional) might really be a service issue (i.e. the policies, procedures or operational requirements of a service or program)
- Who are the providers? Health professionals, government who provides funding to health care system – politicians may not be willing to provide care b/c there isn't a social will to do so
- Do having more psychologists, social workers, nurses etc. produce better outcomes
- Family practitioner is often easiest provider to access

iv. Lack of support and training for health care professionals

System not set up to support providers

- Practitioners not trained to deal with problems that need attention from the rest of the system
- Providers on the front lines might have ideas about how to organize a service but no authority to put it into place
- Consumers feel stigmatized by some providers
- Some providers are paternalistic and are not respectful of person receiving service
- Need greater understanding among providers themselves of the different training and approaches each can offer
- Need to support front-line workers and primary care providers working better with specialists?

v. Need for team approach

a. No one provider that can provide everything – need a range of providers to meet different mental health needs across time
b. The solo practitioner can be effective, but sometimes the absence of contacts and collaboration can be a barrier to getting other needed help
c. Need true partnership approach rather than client-centred approach or sector-service approach

vi. Perceived inequity based on type of mental illness

a. Perception that more "severe" mental illnesses are more visible and therefore more apt to get care
b. Mental health issues are complex
c. Lack of treatment or standardized protocols for dealing with mental health issues
d. Sometimes labelling a person with a specific disorder (e.g. personality) can limit treatments for that person

vii. Inaccessibility

e. People with resources (insurances, financial) are more apt to be able to get help, than are those without
f. High income earners get better services
g. Long wait lists

viii. Need to focus on prevention and public education

h. Need more focus on mental health literacy
i. Education needs to balance between expertise of health providers and lived experience
j. Early intervention seems to be lacking
k. Challenge of putting money into preventive efforts if that, if they are successful, you have the challenge of measuring the absence of something

ix. Need to focus on resilience (individual and community) as key component of recovery

- Communities can help people deal with their mental illness
- Communities provide social networks
- Train people and the community to help people manage and recover
- Important to engage and get input from communities in terms of planning community programming

x. Work environments need to be more accommodating

xi. Government

- More inclusion of municipal government in service/care provision
- Need for legislative change to meet need for mental health services

RECOMMENDATIONS QUESTION 1

l. Government funding for community programs
m. Sponsors and supporters to fund and advantage opportunity to increase mental health literacy

QUESTION 2: How well are systems supporting providers and consumers – what's working and what isn't?

3. What's working?

i. Triage system in Nova Scotia

1. Assess accurately – offer groups. Good service for urgent care, okay service for semi-urgent, trying to improve for regular care

ii. Protocols (albeit time and labour intensive) for providers of service (Ottawa)

iii. When conditions for success are present like having money, having a job, living in a large city with lots of resources

iv. Understanding systems

- How to navigate systems and how to refer among them (e.g. health care, justice education)
- flexibility within systems

4. What isn't working?

i. Less support for people who aren't working or don't have benefits than for those who do.

- A lot of individuals are highly compromised in their ability to seek out services; many people are limited by lack of finances, insurance care, private-care options are unavailable to them, etc.

ii. Difference in accommodations offered across work environments

iii. There isn't the right type or amount of resources needed

- Lack of capacity

- Not enough staff to fill positions in rural areas
- Trying to do more with less is very hard
- There is a mental health component to caring for physical illness

iv. Must be able to keep the flow of information between hospitals or health providers

v. Decision-making and legal rights

- System is not listening to the voice of individuals
- Lack of client choice
- The system isn't listening to the person that is able to make a decision (i.e. advocate)
- Need to think carefully of what are the rights (legal) of a client
- As a provider, difficult to determine if the person is really capable of making a decision
- In Ontario, we have not found the balance between protecting people when illness impairs their judgment and respecting their rights

vi. Insufficient services for children

- Not a good transition from child to adult care
- Lack of services for children (need for diagnostics in order to access services)
- Services that we provide for children are family-oriented, and then, really individualized for adults
- Children's mental health is underfunded in Ontario – under the ministry of children and youth services. Wanted to put it under another ministry and they complained that they were putting two poor cousins together
- Youth services –tried a horizontal government approach – they don't do it well

vii. Need more focus on communication when it comes to public education and prevention

- Some families do not communicate well

viii. System is rigid, not responsive and not coordinated

- We do not have a system for either acute or chronic care of mental illness
- There is no systems-level pathway in terms of a trajectory through the system, as there is for cancer, arthritis, heart disease
- When you spread responsibility across organizations, there is no leadership, no incentive to collaborate, no organization
- Having to jump from service provider to service provider does not help

- Funding the right quantity and mix of different disciplines is a challenge. Disciplines are competing against each other dollar for dollar, instead of working together. Cuts are made to some areas, when really, we need every service
- Seems that opportunities offered are due to happenstance and what may be available in one's geographic location
- Clients want more time with their providers to understand the complexity of the issue and the options available to them
- System is failing the consumer and the provider; consumer may not have choice in who they see, and practitioners are limited in the time and services they can provide
- The issues of service providers and what the patient needs are tied together: What the patient needs is also what the system needs.

ix. Choice of treatments

- There are essential treatment modalities, inclusive but not limited to medication, that in the right circumstance will work
- Consumers feel like first option is to prescribe medication for an issue that may be more complex and/or require more/different services

x. Insufficient focus on prevention and education

xi. **Insufficient inclusion of community services departments in meeting needs of those with mental health problems**

xii. In terms of patient visits, inpatient units are not visitor-friendly (locked in, sterile)

xiii. Mental health is a provincial/territorial responsibility instead of a federal initiative

- The incentive and the resources to deal with the problem are not there

RECOMMENDATIONS QUESTION 2

- Improve communication among providers and families
- A comprehensive, systematic approach is warranted
- Enhance access to services and supports and their systems and resource these necessary providers. Need for flexibility within system and within provider practice
- Need to shift our focus from what the service provider needs to what the consumer needs; top down approaches are ineffective
- Need to have different services that collaborate better together, to develop more partnerships, more communication, better coordination
- Decrease/break down the "silos" in the system and create structure that provides better care for mental health problems
- Include consumers at every decision-making table

- Funding for psychologists within public health insurance systems
- Advocate for legislative change

QUESTION 3: What are the gaps and opportunities to better match demand to supply of mental health services and supports?

i. Need electronic health records that are transferable

- There needs to a sense that assessment is reliable, that people will not have to repeat their stories and assessments each time they meet with another provider
- There is a lack of continuity – have to restart every time a patient enters the system
- Privacy assurance in use of electronic health records

ii. Integration and funding for community organizations

- Counselling service agencies provide various services at various levels. Third sector services are run by community boards and have been reduced as funding has been cut.
- Community organizations need to integrated with other health systems

iii. Unless someone has a family member to advocate for them, people will not get the services that they need

People need to speak up and make mental health care a priority item for parliamentarians. They don't because:

- Fear that it will perpetuate stigma
- People aren't strong enough to advocate for themselves
- People in mental illness crisis can't think clearly
- Feeling that don't have right to advocate for self

iv. Mental health is a non-system at this point

- Need a matrix model rather than a linear model, with the right number of health providers
- Disjointed continuum of care that doesn't encourage integration of services and providers
- Territoriality of services and providers; every system has its own forms, processes, turf, etc. – need to rationalize the system
- Health authorities are working independently from each other and don't communicate within or between provinces.

- Lack of stewardship or accountability because no one is responsible for or in charge of mental health
- There is a lack of program evaluation and therefore a lack of accountability

v. Lack of a commonly accepted standard between assessment and service delivery

vi. Need minimum data sets to

- support advocacy
- catch what is going on with family physicians
- understand how mental health impacts physical health
- develop benchmarks for what is an acceptable wait list time in mental health

vii. Need to consider supply and demand; who are the professionals and where are they?

- Education system for training health provider and needs of society don't match

viii. Need for public education

- Resilience training
- Impart information about what services exist to support mental health in the workplace
- Stigma – people don't trust EAP programs because of it.

ix. Enhance access so that

- resources for mental health go to where they are needed
- benefits (for service and supports) are available

RECOMMENDATIONS QUESTION 3

- Need for electronic health record (EHR)
- Integration of health system (i.e. organized governmental health care system) that includes third sector (NGOs, caregivers, community) to allow patients to move fluidly between them
- Overhaul the entire system to create an actual mental health care system that acknowledges the roles of all the players, community groups, patients, care-givers
- Need minimum data sets

QUESTION 4: What might be some of the quick and not so quick changes we can make so that services and supports are more client-centered and more accessible?

I. System transformation

- Macro level
- Get mental health included in any federal health plans and on the agenda of members of parliament
- Build coalition and partnerships in the system (legal, education, hospital, health care)
- Might not be feasible to completely overhaul the system
- We need a system based on assumption of capacity
- Population health approach
- Support primary care reform to include mental health as a key focus
- Facilitate accessibility
- Money follow the patient – data shows this contributes to shorter wait times
- Invest in collaboration and community programming
- Invest in primary care: give medical clinics lump sum of money and allow them to determine how best to spend the funding across multiple related health disciplines

Level of system delivery

- Health record should reside with person, with family physician having backup
- Establish an identification card with all of one's medical information documented that is attached to person and not health facility or professional
- There are small ways to provide a broader menu of services. It is not only what is available, it is when. It has to happen when the client and family is ready
- Need more collaborative approach to health care. Need incentives to make health care providers accountable for patients' care and the necessary collaboration with appropriate others in a timely manner
- Clients need to be able to go to one place to get all of their care. Provide all care needs at the same time – housing, all treatment, etc.
- Need a system that accounts for concurrent disorders – either substance abuse or developmental/intellectual delay
- Move toward primary care, and chronic disease management instead of episodic care
- New Brunswick's rapid response team is comprised of social workers, psychologists, and/or a psychiatric nurse and a psychiatrist on-call who will come in and assess the care of an individual entering a hospital. This provides quick-access for the patient. It is a code team that provides quick service provision to the individual, and thereby demonstrates that professionals recognize this as an emergency.

- Lack of trained resources and organization of care
- define wait time standards for mental illness
- Support family health clinics and health teams Need centralized communication (i.e., medical record keeping) within health system (ideally would be national and not just provincial)
- “privacy issues” block communication
- Evaluate client satisfaction

Provider level

- Need HHR trained in mental health at entry points where it is needed. Makes a difference if front line workers have training and competencies in mental health assessment
- recognition that some clients/patients with mental health issues can’t express themselves in five minute allotted appointment with family physician
- Encourage the inclusion of mental health when discussing health with family on a general basis. To normalize mental illness and access mental health services, incorporate ideas of well-being, how has illness affected your relationship, your mental health
- Concerns about recording of perceptions when dealing with mental health issues; physical issues, such as cholesterol levels, are standardized

II. Preventative screening and programming

- Consider early screening for specific mental health vulnerabilities
- Help Canadians understand the cost and pervasiveness of mental disorders

III. Education

- Education about the type of services that are available and when they may be needed
- Increase mental health literacy of Canadians
- Don’t ignore signs and symptoms of mental illness among those in your community
- Educate policy-makers
- Private sector and physicians also need to be educated so as not to contribute to stigma
- Develop tool kit (resources, how to…)
- Need recognized champions; people need to share their stories

IV. Knowledge transfer about best practices

- There are a lot of things that we know already that we’re not implementing

V. Cost-benefit analysis of investing in mental health services, evaluation, and research

- Look at Gross National Product and Gross National Deficit; need to develop a formula to demonstrate how the costs in treating mental health issues appropriately can be cost recovered through later productivity in the next ten years
- Use/develop cost calculators for the prison system to demonstrate the cost-benefit-analysis of *not* treating mental health issues

VI. Navigator or helper for consumers to help them navigate the mental health care system

RECOMMENDATIONS QUESTION 4

- A budget/credit card carried by the person and driven by their needs.
- Hospitals and other institutions have to evidence that they are effectively including consumers at their decision-making tables and this should be linked to funding.
- A patient who comes to the hospital with severe mental illness/psychosis should be treated in the same way and with the same urgency as someone with severe chest pain.
- Track wait times for people seeking mental health services, so as to develop better triage services that do not create a stigmatizing situation for individuals.
- Introduce core competencies amongst related mental health professionals (e.g., physicians, psychiatrists, psychologists). Create mental health literacy amongst all people working in hospital emergency.
- There need to be services available for follow-up. It is not just a service issue for people who are entering the system, but also when transitioning back to their homes and communities.
- We need to be assessing whether people's home care situations are healthy and facilitate recovery.
- Conduct more routine preventive screening – we cannot manage what we do not measure.
- Take some of these recommendations (i.e., one per province) and do a long term health cost benefit analysis nationally so that one province isn't jumping in without evidence. Also would help provinces' talk to each other more about their effective practices.
- Menu of educational tools for the consumer when he/she enters a mental health service or emergency room in the hospital.
- Develop tool kit (resources, how to…)
- Support effective treatments – e.g. medication has done a lot of good for people with mental disorders.
- System reform, not only in types of providers and access to providers, but also different human service models in collaborative care to support clients.
- Better use of technology to deliver care (video conference; telemental health)
- Increase resources to small towns (e.g. develop partnerships, use of technology)

- Increase partnerships between services for clients
- We need to address training of front line staff (emergency rooms staffs, police officers, teachers, etc.). Mental health first aid (Australia)
- Need to address the issue about the lack of psychologists in the public system
- Need to improve / educate the Canadian population about mental health issues.
- Determine what funding mechanisms are best? Per capita or needs based because populations differ
- We need a governing body that will establish uniform standards for mental health services across all provinces

WORKING GROUP DISCUSSION
BREAK OUT SESSION 2

QUESTION 1: What is the match between what evidence says is best practice and what is accessible? Where are the gaps?

i. Culture and political will

- Culture within the workplace, and among professions can be a barrier to good team work
- Culture and climate shifted needed; personal stories that resonates with decision-makers

ii. Collaboration

- Continuity in decision-making: different departments in health and government services don't talk; governments and their staff change and initiatives lose traction
- Some family physicians are hesitant to refer a patient to another type of health professional
- We need to have a more comprehensive approach to issues; can't look at housing without looking at poverty and nutrition
- Electronic health networks, etc. are good, but not enough
- Breaking the silos among sectors is extremely difficult (e.g., schools providing mental health system within schools)
- Jurisdictional boundaries and tensions need to be broken down
- If we know what other people's roles are, other professionals' roles, this will encourage collaboration
- Whatever your concept of team, need integration of services

iii. Training and attitudes of health professionals

- Scopes of practice or mandates among health providers can be very narrow; take care of one problem but are not mandated to work on another
- Professionals are also sometimes territorial and don't want to share a patient with another provider who is offering a service that they don't provide.
- Private practitioners focus on areas or practice of interest rather than responding to need
- We need to expand the scope of practice of OT's
- Managers in the health system don't have the necessary expertise in professional administration
- No national standards for mental health care, resulting in vast discrepancy across the country
- Can't change a problem without addressing the training of mental health professionals
- Requirements have to change for residents (GPs, psychology, social work) such that they go into the field for training in mental health (going to the client or family, working with police, working in private practitioners' offices)
- Get rotation in mental health early in training

iv. Financial

- Difficulties affording access to medication
- If you have the money, you have access because psychological services are not covered by public funds
- Family centres tend to get financial support, without requirements that they hire specific health professionals or address mental health care needs; health care decisions not based on epidemiological data
- Often times the services that health professionals recommend are not funded
- Despite agreement among provincial ministers that something is a good idea (agreement in principal), common response tends to be that activity or initiative won't come out of their budget (but not in practice)
- Huge cost associated with number of people who are incarcerated with mental health problems
- Funding is often based more on political views /votes than what health providers or evidence might recommend

v. Knowledge translation, evidence-based practice

- We know enough about what works in terms of mental health service and treatment; gap is knowing how to translate research into guidelines and practice
- We know about what works but we don't afford access to these services
- Difficult to implement guidelines when evidence is weak
- People are not implementing evidence-based research
- Guidelines can constrain service delivery, especially when funders focus on guidelines concretely, rather than by just being guided by them

- Reluctance to let evidence have more weight than previous work experience
- Existing systems seem to inhibit best practice – physicians are struggling to manage needs, pressures, making appointments, contacting other health professionals
- ACT team (back in 1961) is not used much; welln know program is PACT
- Exclusion criteria associated with programs constrains access
- People (consumers) do not know where to go to access evidence-based practice. We are stuck in a transfer model vs. a transition model (people are directed to services, and they are not always the right service to meet their need. A transition model would assist the person in accessing the right services).

RECOMMENDATIONS QUESTION 1

- Right provider right time right place
- Need political will.
- There are opportunities/models to hear of successes, tool kits being developed. Don't have to start from scratch.
- Change culture of professionals and the way trained so that collaboration is promoted.
- Have an entire spectrum of professionals who are addressing all aspects of problems with the mental health patient.
- Improve access to information for the consumer about their service options;
- More community-based services;
- More services in general – in the short run this won't be cheap, it may be more cost-effective in long run to be efficient, but a long-lasting budget increase overall is needed. Recidivism and re-admission rates will decrease over time, however. So, per individual the costs may decrease; overall, with more people receiving services, the costs may increase. This is a contentious conclusion – other cost savings may occur if the mentally ill who are currently served by the criminal justice system become served by the mental health system.
- Gap between services and what is accessible? Media coverage is always about a service failure, never about someone who has received the appropriate services and gotten better.
- If there is one thing that could be changed that would help the next generation, it would be to reduce the cigarette and alcohol consumption of pregnant women.
- Work on the lack of standards for care
- Decrease the overlap between health authorities
- Increase education among sectors and stakeholders
- Find one problem and one politician who is willing to get involved and then work on this one problem.

QUESTION 2: What are the barriers and opportunities to putting together a team that works?

Opportunities

i. Financial

- Many provincial governments (e.g., Ontario, Alberta, BC) are funding primary health care teams, which is a priority in terms of policy and political will.

ii. Knowledge translation

- Learning from community-level success stories, and using existing toolkits and guidelines Consumers and providers need to be knowledge about what each do and provide and how to connect to each other
- We need to increase knowledge among stakeholders of various pressures affecting other parts of the system. This increased knowledge and understanding can enhance practice

iii. Collaboration

- GP and specialist collaboration: Realize that everyone has a separate scope, but also a shared scope
- In rural areas there are better partnerships, collaborations, integration of services because resources are fewer and collaboration is of necessity. In higher resourced areas we aren't forced in the same way to realize that we have a collective responsibility. A community focus helps professionals realize "we have a collective role and responsibility".
- Support for more collaborative training models for health professionals. Conversations at this point need to occur: If we are training someone, what do we really know about access, gaps, inter-professional and collaborative care

Barriers

i. Financial

- Some services are funded and others are not.
- We need sustained funding.
- Health care providers need financial incentives to come together to work as a team

ii. Policy

- Lack of policy and mandate to incent change.

iii. Health System Organization

- Difference between community based service and private practice and each have their own barriers.
- Competition among different professionals: need to enhance respect and value among groups of providers.
- Decision rules around how family health teams are constituted, how pay scales are determined – these vary from team to team.
- Need clarity on who does and can do what in terms of health service (e.g., nurse-practitioner led teams)

iv. Health Provider Training

- Training in silos which don't produce practitioners who can work collaboratively.

RECOMMENDATIONS QUESTION 2

- Rationalize waitlists to reduce wait times.
- Provide informal opportunities for different professional to come together, to facilitate them working together.
- Don't lose sight of consumer in planning and decision-making
- Embrace inter-professional training.
- Value the different expertise of people on the team.

QUESTION 3: What system change is needed to support the development and functioning of teams and services that deliver evidence-based care?

i. Training

- Need for competence-based and standards of training across professions - especially with addictions and co-morbid diagnoses
- How providers were trained 20 years ago is different than how providers are trained now
- Need more opportunities for mentoring

ii. Health provider attitude

- Arrogance among health providers; top-down communication in terms of them telling patients what they have to do

iii. Evidence-base

- Need commitment to program evaluation at an individual level, and at a program level – based on the goals of a program or treatment
- Use the tools and treatments we have that have been show to work
- Consider approach of practice-based evidence versus evidence-based practice
- Team needs sufficient resources to deliver evidence-based care;

iv. Financial

- Sometimes teams are expensive and not necessarily cost-effective considering the outcomes they provide
- Provide funding for provincial/territorial administrative teams to meet with health professionals to review systems
- Need funding for a team approach as opposed to a silo approach – need change in thinking – funding can go toward billing codes, team meetings, clinic model, facilitators to link with communities and physicians
- Specialists are paid for one on one work, not necessarily, supervision, and team/group work.

v. Data needs

- Need data on state of the system in terms of number of mental health professionals, expertise, geographical location, team versus individual practice

vi. Health system

- Consider mental health as a chronic disease and prioritize it accordingly
- Need a system navigator to help patients on all points of access – would be cost-effective

vii. Collaborative team approach

- System needs to mandate a team-based approach that integrates mental health professionals
- There needs to be clarity on what we mean by the term “team” – should include peer-support workers, consumer organizations, family – extent/broadness of team depends on complexity of issue, location of person
- Vulnerable populations need voice; homeless people with mental illnesses have not been included in the forum – they have many problems with access
- Need a core team in one place with access to needed others

viii. Knowledge translation

- Need knowledge translation and transfer so consumers can make informed choices about services and supports

- Teams need to be aware of best practice – someone on team needs to support knowledge transfer among team members
- Knowledge transfer must extend beyond MHCC and into the health system
- Media can help in knowledge transfer
- Funding for knowledge transfer and translation

RECOMMENDATIONS QUESTION 3

- Looking at different remuneration models for physicians
- Better need for cross-training and co-morbidity training (i.e., addiction)
- Evaluation of services (individual and program)

QUESTION 4: What other kinds of change are necessary in order for the right service from the right provider to reach the right person at the right time in the right place? (e.g., changes to workplace culture and context, changes to provider attitude, client expectation)

i. Need to consider mental health is part of health for which consideration of housing, employment, etc. is a must

- Ensure consumers are on the right waiting list for the right service
- Everyone has mental health or a mental health issue at one point in life. Having had a mental health issue shouldn't define you

ii. Health provider training

- Need for specialized training with specific mental health issues
- Need to change requirements of educational programs to accommodate new models of health care delivery like collaborative care
- We need to allocate funds to provide opportunities for mental health teams to "gel" – e.g., one half day per month for a complex case presentation where all health professionals attend, provide perspectives and enhance understanding
- Need mentoring programs
- Some family physicians are not comfortable dealing with mental health issues
- Need cultural change among health professionals in terms of mental illness, collaborative care etc.

iii. Team formation

- Diverse population/needs require diverse team
- Need someone on team whose primary role is the well-being of the team
- Specialists need to interact with team
- Need more inclusion of top-down management
- Teams need to be integrated

- Need peer support workers

iv. Systems

- Facilitate access to all services in one place
- Health providers need to be included in system-change discussions
- Having a case manager (e.g., after having a first episode) is very helpful. If you need employment, social assistance, etc. – they are able to guide you in the right direction or help you navigate the system
- Different system navigation tools and service brokering tools to advocate for you (e.g., for homeless people, people in remote area)
- We need electronic health records
- Settings need to be open to changing their respective forms to a more standardized process

v. Evidence-base

- Resource psychotherapy and make it accessible given that it is evidence-based
- If known treatments work, we should be using them
- Research can't just be done by researchers in universities and by pharmaceutical companies,
- Research needs to focus on different populations
- Research questions need to emerge from the front lines and then go back up to academics
- Need more research on how to recognize triggers so can intervene earlier

vi. Funding

- Need changes in call for proposals toward models that are transferrable to other communities to use/adopt – right now, communities seem very protective of their funding – move toward community information funding

vii. Privacy Legislation

- Confidentiality legislation has become insidious

viii. Consumer inclusion

- Team needs to include consumers and their family in decision-making and ongoing assessment of treatment effectiveness; can't simply defer to will of specialist
- System needs to recognize the patient in the provision of care
- There are different degrees of welcome when it comes to consumer involvement in the process of delivery services

ix. Gap in resources

- Resources are not bad when children are very young, but are very underserviced in grades 7-12
- Difficult to find a family physician in some cities/provinces

x. Education system

- Ongoing education and support for teachers given their dealings with students with mental health issues
- Schools offer an opportunity for early detection

xi. Access

- Difficult to get patients into some programs
- Most consumers don't know where to go for services
- There are long waiting lists when trying to link patients with appropriate services
- Need one door to deal with all issues
  - One door where providers have multiple skill sets to help deal with multiple (concurrent) problems
  - One door approach is where there is truly an opportunity for holistic care within which systematic treatment tailored to different problems can be effected

xii. Policy change, political will

- Members of parliament need education/training around mental health issues
- Government representatives want to be presented with solutions
- Report cards are very useful
- We need to the political will to declare a set of goals re: mental health by a set date

xiii. Collaboration and communication among health providers

- lack of communication among professions
- professionals need to know the expertise of other health providers
- we need to organize meetings around the scope of practice of each professional so that others can learn
- GPs don't know the specific expertise of other professionals so they cannot refer properly
- Turf protection within health professions is a big issue
- In a team setting, everyone brings something to offer
- How can a community care person better address a physician's needs and vice-versa?

- Need to change what we are rewarding and make sure that system-focused activities aren't being rewarded over client-focused activities

xiv. Treatment options

- Consumers ask for, and are open to, traditional and non-traditional treatments (i.e., massage…)
- Patients should be provided with all the options, even if the professional does not happen to be able to provide all the options they discuss with the client – then can make referrals accordingly
- Sometimes more difficult to get service for mental health issues that are manifested internally, as opposed to externally
- We are still very "emergency services-centric"; not always most beneficial to producing effective, desired outcomes.

xv. Employers and insurance companies

- Parity and respect for people off work for health reasons – physical or mental
- Employers aren't always willing to pay for services that employees need when they come back to work
- Seem to give unlimited funds for medication, but limit number of sessions for psychologists
- Build in designated mental health days in workplace health programs
- Employees reluctant to use EAPs or afraid to go on stress leave for fear of future recrimination (e.g. not getting a promotion)

xvi. Mental health literacy and stigma

- Stigma is still an ongoing issue; needs to be addressed at all levels
- Mental health literacy will help with early identification and support people to ask questions and get help
- Make mental health a focus of anti-stigma education and mandate requirement that falls in line with anti-bullying and discrimination strategies
- Need to disseminate information about onset of disorders
- Health professionals need to visit community groups (e.g., boys and girls clubs) to educate community about mental health and mental health services and treatments

RECOMMENDATIONS QUESTION 4

- Large teams with allowance for specialization in the various mental health disorders
- Need someone to look after the well being of the team – someone who understands the dynamics
- Using technology in rural areas to access specialists on a team where there are gaps.
- Identify champion model, benchmarking
- Need to learn from examples that work and bring them home

- Adopt a population-based approach to health and health-care
- Improve the patient/user experience in the system
- Make improvements in a cost-effective manner
- There should be someone on the team who informs the rest of the team about what resources exist
- Increasing the comfort level of people in primary care
- Teachers, nursing home providers are really the front line. Some people don't even get to their doctors. We need to support these people so they don't feel alone
- Need a system navigator or service broker. If you are new to system do not know where to go
- Early detection (work, school, primary care)
- Alignment of services, multi-access one-door, where you can get all the services that you need
- System has to recognize the needs of clients so that they become the consumer and driver of the services.
- Make mental health education mandatory within schools and the workplace

WORKING GROUP DISCUSSIONS
BREAKOUT SESSION 3
NEXT STEPS TO ADDRESSING ACCESS ISSUES

i. In breakout session three, participants summarized their take-away impressions in addition to identifying next steps. Take-away impressions from the Forum discussed in breakout session three are below and are separate from the information collection in the Forum Evaluations reported later in this report

- Yes increased awareness, learned a lot through the two days of presentations, about consumer experience what is working and what is not and international presentations very informative because everybody has the same issues, some are getting more money though, UK and Australia. A lot through stigma reduction. Getting money to do it, still a lot of waste occurring though. People doing what they have always done still.
- Really appreciated hearing about the way in which structural changes to service delivery could improve the performance of access to services, timelines to referrals.
- Sobering realization that the conversations that we are having now are at a different place and level, and understanding of range of solutions, than they were even 6 months ago; it's great that the discussion is still going on.
- Forum shows that we are continuing to grow
- From someone who doesn't work in mental health all the time, I'm surprised that we're only at this point.

- It's 2010 and while so much hasn't happened, a great deal has. It's hard to access and navigate the health system, especially when it comes to mental health.
- Learned a lot of new information that will take to discussions with politicians regarding gaps
- I will go home with a slightly new attitude about how to change things; less tolerant with same old same old.
- International presentations
  - some found them highly informative, while others found them less so
  - International data on programs and health issues was informative
  - Good to learn what is going on in other countries
- Learned that small efforts can make big differences in the effectiveness and deliverability of service
- One participant was looking for more sharing of best practices; we agree on general principles and now need to move toward operationalizing two or three models, learn what works and doesn't work, what users and professionals like, and have discussions around that
- Interesting to see how other countries handle funding private services. They are linking the private system to the public system—using an existing workforce
- It was nice to hear an inside perspective of the challenges in the correctional system
- It was interesting to get a sense of disconnect between services
- The consumer presentations gave a lot of insight; very real
- One consumer felt discussion was repetitive and hopes something will come out of this forum
- Learned to look at things from a psychological point of view and the challenges practitioners face
- There should have been more government representation at the forum – offended that government representative came and promptly left after giving greetings
- Health doesn't seem to have any priority at the Federal level
- MHT representative struck by commonalities in reports back from breakout sessions
- Data agency representative struck by local examples, and how concrete changes could be seen in practice
- MHCC representative recognized need for and plan to include consumer more in future proposals and work so is more inclusive
- Consumer presentation opened eyes to opportunities to work with other disciplines
- Forum allowed people to reconnect with established networks
- Surprised by how many people were known
- Staying connected is the challenge

    - Forum is not structured to promote continued networking
    - Email, phone
    - Delegate list will be very useful for maintaining connects and following up
    - Can any of MHT member associations do anything on their websites to foster further connections and information sharing?
- Opportunity to meet new people
    - Albeit a full agenda with limited networking opportunity
- New and future connections
    - Canadian health professionals will connect with international subject matter experts
    - New connections made with other mental health associations
    - Made contact with people from the government that can help change things
    - Made connections on places to go to for background information for report development
    - On average, 2-5 new connections were made
- Many consumers chose not to include their personal information in the delegate list so unable to stay connected
- As a health provider, I didn't learn anything new, but it validated that I am not alone facing these issues
- Nurses are increasingly being placed in the community to provide mental health services, but this isn't known
- Will go back and examine the various skills and roles of their various team members
- Based on this forum, one health professional decided to say yes to an invitation to participate in an inter-professional and continuing education program
- Will make many people reflect on how they treat patients
- Some weren't aware of role of many family physicians as "gatekeepers"
- Will work on service standard guidelines, and the role of psychology in relation to primary care and will do this provincially and with the college of family care physicians
- Gained understanding of the complexity of the many sectors that are involved in providing care
- Recognition that current system organization can interfere with the provision of mental health services
- Other provinces are also discussing disconnect between public health and primary care
- Will try to get peer support for patients, in addition to mental health professionals
- Funding
    - Gained knowledge about different ways government provides funding
    - Short-term funding for programs is not useful b/c there is limited sharing of learnings
    - Will bring issues forward to funding agencies when they solicit input from stakeholders
- Consumers

    - Consumers had increased awareness of challenges from the health provider perspective
    - Need to give consumers a voice
    - Consumers stigmatize mental health providers (e.g. patients don't have an issue being referred to a cardiologist for a heart problem, but resist being referred to a psychologist for a psychological problem)
- Dissemination moving forward
    - Wish that when successful services, systems, have been shown in a jurisdiction they are kept going, applied to the rest of that jurisdiction, and replicated across provinces
    - Plan to take the learnings back to my department and use them as a criteria for how are we approaching service delivery
    - Will share information to social working group
    - Important to get this information to members of MHT associations (i.e., members of their own professional associations)
    - Will follow-up on some of information presented such as Australian initiative
    - Will write an article for our newsletter about the forum and sensitize one's family health care group to the issues
    - Will bring issues forward to clinics and committees on which people sit
    - Will bring issues forward to their union
    - Plans to take some of messages that were heard and incorporate them into their advocacy initiatives
    - Will invite some of delegates (e.g., youth representatives) to come speak to their residents about population-specific mental health issues
- Increased knowledge
    - Knowledge about burden of mental illness
    - Non-health providers learned something new
    - Gained awareness of role of other health professionals
    - Learned a lot, but many key stakeholders were missing from the discussion
- Leaving forum motivated
- Delegates representing data collection agencies will look through their current surveys to see if there are any needs that are not being addressed in questions
- Will look at issues in relation to mental health strategy

ii. Increase awareness, understanding and use of knowledge tools, products, approaches, models, innovations, and health system reform issues

- Necessity of evaluation from a health provider and consumer perspective
- Increased need to have a community engagement focus
- We will have failed if we don't embed mental health care into the primary health component of our health care. That is how we make it mainstream. And we take a population health system, identify the gaps, create advocacy groups.

- Asking questions about end of life care has become fundamental; we need to get there for mental health.
- Provincial action is all dependent on MHCC reports, but we get waylaid in discussions rather than action/implementation.
- The MHCC needs to be challenged to bring mental health into the mainstream; we need to focus on prevention and promotion and then well-being and recovery.
- We haven't changed our health system to match the times; physicians shouldn't be the only ones who can bill
- We need benchmarks and reports
- We need to advocate, develop a campaign
- Public needs to get behind this issue to push political will
- Psychiatrists can take on more referrals when they can hand a patient back to the family physicians
- Social inclusion, having a system that includes people as citizens. This was a very powerful piece.
- One consumer wants to see more money put in by government to integrate CBT and shift focus away from meds
- Important to include the right representatives and stakeholders
- Seems we are at a cross-roads
    - Will we move toward a focus on saving costs or improving the quality of services?
    - Being efficient is one thing, being effective is more important
    - We know what we should be doing, but again it is a matter of choosing what we want to do.
- Prescriptive approach
    - May be beneficial in fixing the oft-quoted impression that putting money into mental health is a black hole without effective outcomes
    - Sometimes the prescriptive approach is too limited (i.e., set number of sessions) and someone may need something different and then not be able to get it b/c of socioeconomic barriers or other barriers (e.g. don't have a GP, can't access a psychiatrist/psychologist)
- Can't move towards a model of separating mental from physical health
- Need more of these types of dialogues and opportunities to learn from each other (i.e., their successes, the successes of other professionals across Canada and internationally)
    - We need a good practices conference – some forum where we can learn about everybody's innovative solutions and learn from those.

- These issues are systemic, and we need more key players at forums such as this (e.g., representatives from education, justice, etc.)
  - We need to have wealthy, influential businesspeople at the table b/c they can help get the word out to politicians
  - Insurance companies should also be at this type of forum
- If we want real change, we need survivors and families to start a grassroots movement to which politicians will be forced to respond and listen
  - We need to get mental health into the 2014 health accord
  - Politicians need to understand the costs of not addressing mental health issues
- Clarifications/nuances re: term evidence-based practice, integration of patient preferences alongside evidence-based practice
- Need for more communication about what works

iii. Decreasing barriers and increasing facilitators

Barriers

- Access
  - Service not happening at the right time, not early enough, people are reaching out for help and interventions are not available
  - Times of distress are not the times to try to find needed services
  - Not knowing where to get the information needed

- Funding
  - Social status plays role in treatment access
  - Short-term rather than sustained funding for projects
  - Lack of funding
  - Fee structures
  - People can pay for assessments but then can't pay for the treatment. What other systems could provide mental supports?

- Knowledge translation
  - Way in which information is provided to users of the mental health system. Patients do not always know the options available to them for their own mental health care. They need to be told that there are a variety of paths for mental health recovery, groups, psychotherapy, medication, etc.
  - Across all levels of the system, lack of knowledge re: what is effective
  - Fear of sharing information
  - Lack of awareness of the competencies of other professionals

- Lack of awareness of what evidence-based practice is
- Not making best use of technology

- No benchmarks
  - In absence of benchmarks, there are no standards – we need both
  - In program evaluation, have to show actual number of people to have an impact
  - Secrecy and lack of transparency in program processes such as psychology accreditation process
  - Self-management techniques and peer support are useful but not being captured in surveillance strategies

- Lack of resources
  - Scarcity of the number of people trained to work in the system (e.g. not enough psychologists)
  - Many professionals are burdened by lack of time, burnout, resources

- Health provider training
  - Inter-professional education is important. Some universities promote this but if you teach outside your faculty it doesn't count towards your work credits

- Health system structure
  - Confidentiality issues
  - System is all or nothing
  - Nobody to help people navigate system
  - Multiple barriers add up even when they are small
  - silos and turf issues
  - Fragmentation in health system with a lot of silos
  - Many recommendations for a system navigator but how would this be operationalized
  - Recognition that mental health needs to be included in the health accord for 2014 if we want to improve access
  - The public health system needs to be expanded to include private psychologists
  - The education system needs to become involved in delivering mental health care, regardless of current issues related to the lack of resources, school culture and system organization. Presently, school psychologists focus on testing, rather than providing mental health care support
  - People with mental health issues should qualify for home care

- Lack of political will

    - We may need to lobby for more money to be taken from physical health care and given to mental health care.
    - Need political will.

- Lack of collaboration and communication
    - Between consumer-organizations, consumers, families of consumers and mental health professionals
    - Important to break down glass walls and be open to collaboration
    - Lack of training in collaboration

- Stigma
- Mental health illiteracy
- Need for early intervention across sectors, not just health
- Kirby, Romanow and even Tommy Douglas – their reports and actions have bred separation between disciplines
- Even when we have reports with recommendations, there is no system in place to take charge of implementing the recommendations
    - Spend much time talking about barriers rather than doing something to break them down
    - Important to follow-up on words from meetings

Facilitators

- Collaboration
    - Growing willingness to collaborate - professionals with consumers, clients, patients
    - Recognition by professionals and community health workers that they have complimentary roles to play
    - Holistic care, holistic medicine: Physical, medical, psychological, spiritual.
    - Have a registry of service providers so who does what is accessible to all health care providers
    - Many people seek support from pastors and religious counselors
    - The use of innovative work forces

- Communication
    - Electronic health records could facilitate communication and flow of information
    - Internet technology can provide useful information

- Education
    - Funding for conferences such as this one

- More informed consumers
- Forums such as this
- Mental health literacy amongst the population.
    - People need to be aware of what a serious issue mental health problems are
    - Educating the public about common mental health issues
- Addressing stigma
    - It is still the elephant in the room that nobody wants to talk about.
    - Celebrities and champions are becoming advocates for mental illness (e.g. postpartum depression)

- Advocacy
    - MHT needs to take leadership role on pushing issues that come out of the forum forward
    - Having legislation in place

- Health system structure
    - Having a better integrated system (e.g. like firefighters)
    - Identity card with all of your records
    - Having government funding to psychology, especially when it comes to treatment
    - Having someone to help a person navigate the system
    - Build an audit team that focuses on client satisfaction.
    - Identify your standard operating procedures, common goals, standards, guidelines on how you achieve your mission and the processes that help you achieve the guidelines
    - Changing things at the local level
    - Peer support workers, case management
    - Recognizing and including other determinants of health such as housing in the health care system
    - Heterogeneity in types of professionals available to provide mental health support
    - Having a systemic approach to meet a need, that shows leadership, policy commitment, population-wide
    - Establishing priorities
    - Office re-design and methods that lead to efficient use of multi-disciplinary team
    - Making use of local initiatives to improve access

- Health provider training
    - Training receptionists of family physicians in mental health first aid
    - Better trained family physicians in mental health

    - Need more training for health professionals in terms of current evidence-based treatments

- Evidence-base
    - Evaluating and measuring outcomes to show that a program is working
    - Effective treatments exist, but aren't always known
    - Need to promote evidence-based practice, but in a smart way

- Incentive and recognition
    - Have recognition for people and institutions that strive for and reach excellence

- Primary care
    - Screening tools in primary care
    - Getting primary care, which must include mental health, on the band wagon

- A renewed focus on patient-centeredness

Recommendations about dissemination of Forum Proceedings

Target audiences for dissemination

- All participants at forum should receive copies of the report
- People that were invited to the forum, but didn't attend
- MHCC and its committees
- Health Canada
- Ministries/Departments of Health at federal level and provincial levels
- Various ministries
    - Corrections
    - Education and early childhood development
    - Welfare
    - Housing
    - Justice and public safety
    - Child and youth services
    - Community services
    - Seniors
    - Labour
- Government officials at all levels
- Managers in the public service
- New governor general
- Professional associations who put on the forum, along with the members
- Federation of consumer committees
- LHINS

- PEI Minister of health and wellness
- CEO of health PEI
- Unions (particularly those that represent people in health services industry)
- Major insurance companies (e.g., Sunlife, Great West Life, Cooperators)
- Major employers
- Operation directors in health facilities (community and specialized hospital)
- People who have decision making authority
- Relevant CIHR institutes (e.g., (neurosciences and mental health, human development and child and youth health, gender and health, aboriginal health, health system research)
- Canadian Health Services Research Foundation
- Public Health Agency of Canada
- Training programs, college and university level, that train people in related disciplines
- Major advocacy organisations
- Media outlets (reporters who have shown interest in mental health issues, such as André Picard of the Globe and Mail)
- Prime Ministers Office
- Clerk of Privy Council's Office
- President of Treasury Board Secretariat
- Industry Canada
- Chamber of Commerce
- Conference Board of Canada
- Chief Public Health Officer for Public Health Officer of Canada
- CAMIMH and its members
- Consumer groups
- Office of the Correctional Investigator
- Potential users of information (e.g. Statistics Canada, Canadian Institute for Health Information)

Cautions and specific recommendations for dissemination of Forum Proceedings

- Concern that this not become a well-meaning report for which there is no action
- Need a plan for moving the information from the forum forward, especially in terms of policy recommendations
- Need champions and advocates
- Education system needs to have a greater inter-disciplinary focus
- Participate in public forums
- Participate in community planning tables and town hall meetings

- Establish a media profile with a series in the Globe and Mail or some other media outlet (e.g. crisis and wait times, unlimited funding for drugs but limited funding for psychological services)
- Establish a report card
- Create a one-pager or short summary to accompany full proceedings report
- Each MHT member association should write a short summary for education purposes for their membership